

A CASE STUDY OF COMMUNITY RESPONSE TO A HEALTH CRISIS FROM A COMMUNICATION PERSPECTIVE

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The city of Austin is a small community in Southern Indiana that experienced a large HIV/AIDS outbreak which infected over 180 people. Due to rapid spread of the disease from shared needles during intravenous drug use, a public health emergency was declared in March 2015. This epidemic was a symptom of the overall communal health issues within the area related to drugs, crime, prostitution and poverty. These problems affect residents' physical and mental health, however, often go unaddressed due to limited resources, healthcare and education. Organizations within the area were affected by the epidemic, and many provided a response to help combat the issue. The purpose of this study is to examine how organizations respond to a health crisis from a communication perspective.

Research question one is, what was the level of coordination between the seven organizations during the HIV/AIDS epidemic? Research question two is, what was the public's response to the effort made by the seven organizations? This study interviewed seven participants and a thematic analysis was conducted that discovered four themes: coordinated response, uncoordinated activities, response time, and inadequate response. In response to research question one, the levels of coordination were infrequent with the seven agencies. Research question two found multiple areas that indicated the agencies approach ineffective in adequately informing the public. The agencies' efforts displayed a lack of coordination and poor timely response to the crisis.

These issues show it is imperative that we develop a resilient health system to operate systemically. By implementing communication for whole health, it would provide a resilient system for agencies to understand and develop coordination and collaboration between each other. With a sense of coordination, they would then be able to execute ways of promoting and living out better physical and mental health (Parrish-Sprowl and Parrish-Sprowl, 2016).

Keywords: Organizational Communication, Coordinated Management of Meaning, Communication Complex, Communication for Whole Health, Health Crises, Resilient Health Systems

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Rationale

Health crises occur all over the world and agencies who are supposed to be responding to the issue with their expertise, lack coordination and are unable to deliver a successful way in managing the problem. This study will look at a particular health crisis and take a deeper look at the response where things were coordinated, uncoordinated, and the implications when collaboration was good and when it was broken down. By understanding how multiple organizations responded to this epidemic, it will shed light on how the organizations could have worked together as a system to create an understanding of the health issues occurring and how the organization's choices affected the response of the public. Furthermore, by considering how well we manage these types of health crises depends on how we respond to them. Taking a communicative approach to managing health crises will provide a deeper understanding in creating a coordinated response given by agencies.

Literature Review

A small community in Southern, Indiana faced an HIV/AIDS epidemic in December of 2014. By spring of 2016, over 190 cases of HIV/AIDS was confirmed within the area (Chan, 2016). Public health crises have been experienced globally but how agencies respond to the issues provides different outcomes (Shoaf, et al., 2014). In this chapter, the response of agencies to the community experiencing this health crisis is examined through a case study. This section will also provide explanation of why coordination is imperative for agencies during health crises.

The community affected was already faced with many challenges such as poverty, prostitution, crime, drugs, limited resources, funding, healthcare, and education that are essential to living a healthy lifestyle. People who are in poverty, abuse drugs, and struggle with many of these identified issues have more physical and mental health problems than people who do not have these experiences (Mukherjee, 2013). This health crisis is about an HIV/AIDS epidemic that is fueled by a drug problem however it is just part of the larger issue that is occurring within the area. This health crisis is part of the symptoms to a larger community health system. The current system in the area has been experiencing many of these challenges for decades and is almost designed to keep people from being physically and mentally healthy.

Delving further into the problem, when communities experience public health emergencies, many agencies and organizations know how to respond regarding their particular concerns, however, they do not typically have a plan of responding in coordinated ways. Public health crises are multi-faceted and as a consequence, different levels of government, nonprofits, and businesses respond in uncoordinated ways. The best response to a health crisis is one that provides a coordination between all of the different systems to work together and provide a collaborative response that will lead to a communal health system (Shoaf, et al., 2014). Cross-sector collaboration is a desirable strategy to address the public health challenges of society. This can be accomplished by multiple types of sectors working together such as: nonprofits, businesses, philanthropies, the media, government, and community by collaborating to manage problems humanely

and effectively (Bryson, Crosby, and Stone, 2006, p. 44). The need of collaboration between agencies is well described by the following excerpt:

“Collaboration between agencies is defined in the literature as “a process in which organizations exchange information, alter activities, share resources, and enhance each other’s capacity for mutual benefit and a common purpose by sharing risks, responsibilities, and rewards.”^{1, 2} Collaborative efforts are important for partner agencies for many reasons. Joint efforts can provide outcomes for partner agencies that may not have been accomplishable individually, as services and programs can be coordinated and resources can be pooled. These outcomes can include enhancing advocacy and resource development, creating more recognition and visibility, providing a more systematic/ comprehensive approach, and granting additional opportunities for new projects. Collaborations may also prevent duplication of effort by various agencies. Effective collaborations promote team building, a sense of ownership, and an environment that provides the maximum resources for success.³ In a review of empirical studies on public health partnerships, Mays and Scutchfield found that most studies provided evidence that partnerships between multiple agencies promoted better health outcomes at the population level or, at a minimum, promoted policies and practices that over time would potentially improve population health” (Shoaf, et al., 2014).

Historically, agencies have not collaborated and will treat these types of issues separately. Each organization will typically take a different approach to the problem possibly coordinating or not coordinating with other agencies. How we respond to public health crises is important because coordinated agencies play a large role in providing an effective response. When organizations are uncoordinated, it creates confusion, duplication of efforts, cracks, ill will, bad feelings, and less effectiveness in addressing the issue. Uncoordinated organizations can also cause people to take unnecessary actions, cause long-term community and health problems, and a waste of public dollars being used. Consider a global health crisis such as the Ebola epidemic and the effects of the response provided by the World Health Organization (WHO), over 11,000 deaths,

national health systems came to a halt, moved backward in social and economic gains, created worldwide panic, and cost billions of dollars in short-term control efforts and economic losses (Moon et. al, 2015). According to the Harvard Global Health Institute-London School of Hygiene & Tropical Medicine Independent Panel on the Global Response to Ebola, they found that it caused, “immense human suffering, fear and chaos, largely unchecked by high level political leadership or reliable and rapid institutional responses” (Moon et. al, 2015). This panel also largely suggested a reform due to the alarming lack of local public health systems and leadership when it came to providing an effective response to the Ebola epidemic (Moon et. al, 2015). The global response provided to the greatest Ebola crisis in history was deemed “late, feeble, and uncoordinated” (Global Ebola Response: Late, Feeble, and Uncoordinated, 2015). Understanding the threats of infectious diseases that occur anywhere in the world are a threat everywhere because we are so connected and it is important to start operating systemically for health (Global Ebola Response: Late, Feeble, and Uncoordinated, 2015).

Now consider a national crisis such as Hurricane Katrina and how the government and other agencies responded to the natural disaster. Government responders were unable to provide the most basic protection from the damages of nature (Moynihan, 2009). The poor response of organizations arose from the failure to manage many factors that include: failure to convert information to the public for the level of preparation needed, federal responders did not actively engage, the Department of Homeland Security (DHS) was unsure of how to use its resources and authority, and other agencies such as the Federal Emergency Management Agency (FEMA) were inadequate due to weakened

funding, authority, and resources during the Bush administration (Moynihan, 2009, p.1 and Perrow, 2006). If these organizations would have coordinated, what type of response could have been provided during this disaster? The issues of agencies being uncoordinated become clearer when considering the effects of the Ebola epidemic and Hurricane Katrina. Furthermore, it would be valuable to look at this issue from a communication perspective because it would illuminate the systemic conversational patterns, the structure, and give us ideas about how we could do better and be more prepared for future health crises.

To illuminate the issues of uncoordinated agencies, it would be beneficial to look at public health crises from a communicative perspective. The lack of coordination between organizations has been reviewed through many frameworks, for example, resilient health systems. A health system resilience is, “the capacity of health actors, institutions, and populations to prepare for and effectively respond to crises; maintain core functions when a crisis hits; and, informed by lessons learned during the crisis, reorganize if conditions require it” (Kruk, Myers, Varpilah, & Dahn, 2015). Resilient health systems are characterized by five elements: aware, diverse, self-regulating, integrated, and adaptive (Kruk et al., 2015). During a crisis or aftermath of an issue, health systems that are resilient provide good health outcomes and protect human life (Kruk et al., 2015). Resilient health systems take into account the complexity and adaptiveness of health care systems that recognize the response that is provided to a crisis or outbreak in which, needs to include a health-care delivery system that is functioning, proactive, and provides a strong public health response (Kruk et al., 2015).

Consider the Ebola epidemic, this health crisis illustrated many areas of resilience that were lacking in coordination which included the health actors being unclear about their roles in all levels of the global health system. Health resilient systems strive for coordination between health actors that include clear communication and the sharing of information (Kruk et al., 2015). This approach allows for a more integrated response with delivering health services that include public health activities and public communication that is coordinated. This shows the significant role that coordination plays into how crises can be managed more effectively. Although many have had different approaches to agencies coordinating, it is still worthwhile to take a communicative perspective on this issue as it would provide a valuable look into the correspondence of agencies.

A communication perspective is, “viewing the events and objects of the social world as made, co-constructed by the coordinated actions of, persons-in-conversation” (Pearce and Pearce, 2000). The Coordinated Management of Meaning (CMM) is a communication theory that provides an understanding in the ways “of which our social worlds are made within patterns of communication and how best to co-construct patterns that enable people with incommensurate social worlds to live together in peace” (Frey and Cissna, 2009). CMM can be utilized as a practical theory, for example, it helped form the Public Dialogue Consortium (PDC), “a not-for-profit organization dedicated to improving the quality of public communication” (Pearce and Pearce, 2000). This example of the PDC shows how a communication perspective provides a collaborative structure to communities and the effects of what happens when collaborations exist through a communicative framework. In 1996, the PDC approached Cupertino,

California's city manager and provided a proposal of a project that is collaboratively designed to identify the most demanding issue within the community and then include it in a more effective and productive form of communication. The identified problem that residents felt most concern about was the quick change in ethnic composition of the city. In 2000, a survey was conducted and found that 82% of residents agreed or strongly agreed that the city "is doing enough to ensure that members of all ethnic groups feel welcome in Cupertino" (Pearce and Pearce, 2000). From surveys conducted in 1998 to 2000, an increase in one item of 28% to 49% discovered that the increase in ethnic diversity made "no change in how I feel toward people of other races" (Pearce and Pearce, 2000). The success of their project was shown through many events such as: a public meeting where residents discussed many intense topics involving ethnicity about how they have previously been handled and how they should be handled in the future, continuing the activities provided by the PDC, the collaborative which was established through an organization of K-8 and high school districts, and more (Pearce and Pearce, 2000). The communication perspective led the PDC group to focus their efforts on creating conversations that would have not existed otherwise and shaping these conversations in certain ways. This resulted in three understandings of managing the design of conversations about the problem by focusing on their inclusivity and quality, treating "talk" as an action instead of a substitute for it, and lastly, developing an alternate model for the city government functioning (Pearce and Pearce, 2000).

To extend upon CMM, it is a theoretical concept known as communication complex. "Communication complex shifts our attention to the pattern that is created

when people talk” (Parrish-Sprowl, 2014). Instead of understanding what each person is doing, it provides us an opportunity to become interested in what we are creating together. It also promotes perturbation in which means that greater health can be promoted when we can alter patterns that are undesirable because we choose how to intervene (Parrish-Sprowl, 2014). Communication complex can be used to improve or develop better response to health crises. It considers processes, patterns, and perturbations that lead to understanding health within communities (Parrish-Sprowl, 2014). “By considering the systemic nature of communication and the patterns formed, we are able to construct environments that are more collaborative and more successful in creating meaningful and successful change” (Parrish-Sprowl, 2014). When communication complex is specifically applied to health, it is developed into what is known as Communication for Whole Health. Communication for Whole Health (CWH) provides a way of thinking about creating resilient health systems (Parrish-Sprowl and Parrish-Sprowl, 2016). A resilient health system has the ability to: provide effective responses to crisis situations, adapt to environments that are changing, and regularly produce health outcomes that are positive (Parrish-Sprowl and Parrish-Sprowl, 2016).

When communication for whole health perspective is applied, it brings to light how collaboration can exist in communities (Parrish-Sprowl, 2015). This approach can help communities develop collaboration during health crises because it allows them to understand what they are co-constructing together (Pearce and Pearce, 2000). This perspective is valuable because it focuses on what we are making and how we should go about managing the conversations in between the community (Parrish-Sprowl, 2016).

The whole system is interconnected as the health that is developed in the community is connected between all of the agencies and residents by the way they talk and the conversations that are had about health. How well do all of these things work together in order to create a system that develops a healthier community? Considering the CWH perspective that addresses the issues of this community this will allow for a new and improved type of way to manage health crises (Parrish-Sprowl, 2015).

This public health crisis has been significantly caused by the large drug problem in the area. The drug issue that they are confronting has transitioned from primarily being about heroin to the newest and hottest drug for intravenous use, known as, Opana. Like many rural areas in the U.S., methamphetamine addictions are a particular problem and if this issue weren't already pressing, they have also developed a wide spread use of Opioids (Wisniewski, 2012). Law enforcement officials declared that Opana it is a growing issue and is leading rural communities in prescription drug use due to the ease of access, price, the high that is gained, and the capabilities of sharing one pill (Wisniewski, 2012). Due to these types of abilities, Opana has been significantly linked to the outbreak of HIV/AIDS because residents of the community are sharing needles and spreading the disease. Officials have confirmed that this is the largest HIV outbreak that the region has ever experienced (Ungar, 2015).

Intravenous drug use is a growing problem in the United States and more specifically, within the rural communities of America (HIV/AIDS and Drug Abuse: Intertwined epidemics, 2012). Intravenous drug use is an issue because it stimulates

needle-sharing in which plays a significant role in transmitting HIV (HIV/AIDS and Drug Abuse: Intertwined epidemics, 2012). When a person is under the influence of drugs such as: Opana, Meth, Heroin, etc., they are more likely to take part in behaviors that are risky such as having unprotected sex with a partner that is infected. HIV symptoms can be exacerbated if a person is actively abusing drugs or is addicted because it can cause greater cognitive impairment and neuronal injury (HIV/AIDS and Drug Abuse: Intertwined epidemics, 2012). Treatment for intravenous drug use is an important preventative measure. This includes the types of treatment such as: risk reduction counseling and reducing or stopping their use of drugs that could lead to risky behaviors that contain unprotected sex or injection. HIV and AIDS has been linked with abusing drugs and addiction since the beginning of the epidemic. It is due to the increased risk of contracting and transmitting HIV and making the consequences worse (HIV/AIDS and Drug Abuse: Intertwined epidemics, 2012). Intravenous drug use is growing in rural communities due to the lack of healthcare, education, and other resources that make up an effective community health system.

The World Health Organization (WHO) stated in their constitution, "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being" (Western pacific regional strategy for health systems based on the values of primary health care, 2016). Health systems should be effective and efficient to give to the progressive realization of the right that everyone deserves to obtain the highest level of healthcare (Health systems, 2016). All people should have access to a functional healthcare system in their community that provides effective services, health information,

and quality of care (Jha, Godlee, and Abbasi, 2016, p.1). Considering a health system that is “good”, would be one that provides affordable, equitable, and quality services to all people, when and where they need these (Health systems, 2016). A health system that is well-functioning provides a balanced response to a population’s expectations and needs. According to WHO, a health system is accomplished by, “improving the health status of individuals, families, and communities; defending the population against what threatens its health; protecting people against the financial consequences of ill-health; and providing equitable access to people-centered care” (Health systems, 2016). People should not develop or die from a preventable or treatable condition due to their economic status, lack of community engagement, education, etc. (Jha, Godlee, and Abbasi, 2016, p.1).

Providing community focused primary healthcare, needs to be reinforced within the rural area and will require coordination between all organizations (Maeseneer, et al, 2008, p. 518). This cross-sector collaboration between organizations will allow for all diseases to be treated and prevented in a systematic way (Maeseneer, et al, 2008, p. 519). By creating a comprehensive community-wide health program, primary care can be strengthened through improvement of health education, infrastructure, and investment in resources. Health systems play a significant role in communities by providing a way for all organizations to function wholly instead of separately in managing health crises. Beneficial community outcomes would be achieved for a rural area experiencing a health crisis with this approach to managing the issue and creating a community health system (Bryson, Crosby, and Stone, 2006, p. 44).

To understand how to build this type of health system, the following questions were developed to understand the nature of coordination between agencies and how the public responded to the agencies efforts. These questions will provide a way to understand health crises, the responses provided, and show the importance of agency collaboration during public health issues. Furthermore, these questions will help uncover how a communication perspective would benefit and improve health systems to build healthier communities.

Research Questions

RQ1: What was the level of coordination between the seven organizations during the HIV/AIDS epidemic?

RQ2: What was the public's response to the effort made by the seven organizations?

Background

In early 2015, Austin, Indiana became part of common household conversations by making headlines not only in the United States, but internationally by gaining attention for an HIV/AIDS epidemic that consumed the small community. HIV/AIDS has been an ongoing issue that has impacted countries, states, large cities, and as we have come to realize, even some of the smallest communities. An epidemic was declared in the State of Indiana in March of 2015 for one of the smallest counties known to the state, Scott County. This county has a population total of 24,181 and is divided up into two cities known as Austin and Scottsburg. Austin is the smaller city that is made up of 4,295

people and has a total area of 2.58 square miles (Scott County US Census Bureau, n.d.). Scott County School District 1 is the only school in the city of Austin and has a 78% rate of students that are on free or reduced lunch and textbook, which indicates the level of poverty in the area. A significant amount of residents lack education and educational opportunities. Additionally, over 23% of the residents in Austin live below the poverty line (Paquette, 2015).

The health problems in Austin began long before the HIV/AIDS epidemic occurred. This epidemic is only part of the issue and is identified as a symptom to the overall communal health issues within the area. The people of Austin experience many problems that affect their physical and mental health such as: drugs, crime, prostitution, poverty, limited resources, healthcare, and education. Furthermore, these issues relates to all manner of health indicators. People who have higher levels of physical and mental health problems have experienced poverty, drug abuse, and struggling with many of the identified issues above (Kurtzleben, 2013 and Mukherjee, 2013).

The health crisis is about HIV/AIDS, however, it is fueled by a larger drug addiction which is a major symptom that affects the community health system. According to Ruralhealthinfo.org, factors contributing to substance abuse in rural America includes: poverty, unemployment, low educational attainment, isolation, and high-risk behaviors (Rural Health Information Hub, 2015). The effects of this abuse can be seen by the increase in crime and violence, spreading of infectious diseases, fetal alcohol syndrome, risky sexual behavior, homelessness, driving while intoxicated, and higher levels of

unemployment (Rural Health Information Hub, 2015). Austin has seen an increase in all of these side effects of substance abuse which clarifies how the community was already in a sense of crisis before the HIV/AIDS epidemic occurred.

The drug issues within Scott County have been primarily around opioids and is a major problem that has over taken many of the citizen's lives. Opioids are a narcotic that are a type of pain medication. This type of medication is typically utilized for pain that is more severe than a muscle ache or mild headache. Opioids are prescribed to help control pain and if recommended for a long period of time, can increasingly become less effective (What are opioids, n.d.). Those taking these types of drugs might find themselves needing more and more of the drug to obtain the same effect in reducing the pain. When using an opioid over an extended period of time, the user's body can develop a dependence on the drug because their body has become so used to the drug that withdrawal symptoms will occur (What are opioids, n.d.).

The drug that was primarily used in the Austin area was OxyContin due to it being easily obtainable and affordable. In 2010, the drug companies were able to change the coding of OxyContin, so drug users were unable to manipulate the drug for intravenous or snorting purposes (Vimont and Besson, 2012). The drug that has helped lead to the HIV/AIDS outbreak in the Austin area is known as Opana. Oxymorphone or more commonly known as "Opana," is an opioid that is a powerful painkiller that drug users turn into liquid form by crushing it and then dissolving it into water so it's easily injectable (Goodnough, 2015). Opana is more deadly than OxyContin because it is more

powerful per milligram (Vimont and Besson, 2012). This drug is an extended-release pill, which is what makes it more lethal, because the user crushes it, and it releases the drug all at once, therefore, giving the user an immediate high (Vimont and Besson, 2012). Drug users in this area were unable to gain access to multiple needles, in which, led them to sharing needles. Substance users obtained this drug in multiple ways by purchasing opioids from what is known as “pill mills,” prescriptions from their own doctor, elderly people who had prescriptions, and local or passing-through drug dealers (Vimont and Besson, 2012).

Austin has lacked significant healthcare resources and social support to ward off this problem that was gaining substantial momentum. Dr. William Cooke is the city of Austin’s only doctor and sensed that an issue was building within the small community. Dr. Cooke feared that drug users were obtaining needles in the most accessible way possible to feed their addiction, whether it was from sharing with another user or using a discarded needle found on lawns (Paquette, 2015). For the past 5 years, the city has been begging for help with this crisis, whether it was by providing more funding to employ additional police officers, or to have more available healthcare resources, such as: clinics and mental health facilities.

In fall of 2014, the Disease Intervention program from the Indiana State Department of Health (ISDH) that primarily provides resources and prevention for STDs, discovered the outbreak in Scott County. They found that an abnormally high level of individuals were infected in the Scott County area and more predominantly, in the city of

Austin. This group then notified the Center for Disease and Control (CDC) of the rising numbers and the concerns that were being raised due to these numbers. By December, the CDC had been in contact with the State of Indiana to notify them of the health crisis. During this point, 80 cases of HIV had been confirmed for Scott County, due to the use of injection of the drug Opana or having sexual contact with an infected person (Williams, 2015). This resulted in the State Department of Health contacting the local representative to notify him of the growing issue in the area. The state took action in March, especially after the area started gaining significant national media attention that included TIME magazine, the Washington Post, Wall Street Journal, CNN, as well as international news media sources. Indiana's Governor, Mike Pence, declared a public health emergency in March and issued a "one stop shop" in the county where people could come to the clinic to get tested, exchange dirty needles for clean ones, and resources to obtain proper identification such as birth certificates and drivers licenses, so they could apply for Medicaid. The county health department was then in charge of running this clinic and passing out the needles. After this clinic was set up and started being utilized by those infected, the numbers leveled off and the state removed themselves from the situation.

The complete ramifications of this epidemic might not be known until years from now. The spread of the disease has been contained within the area but the Health Department cannot pin point the exact individuals exposed to the virus. They know that hundreds have been in contact with those who have been infected but cannot locate all of these individuals and are concerned some are unaware and potentially spreading this

virus. However, some have been located but refused to be tested while some only had an option to seek this help because they had no other way of treating the problem.

Methods

Study Design

This study was handled from a qualitative approach to help understand social and human behavior that highlights the collection of “thick” data (Willis, 2007). A combination of archival research and interviews were conducted to develop a description and understanding of the working case. A phenomenological research approach was utilized for this study to understand the experiences of a public health crisis about how organizations responded to the issue. This approach was applied by using the communication perspective that includes the Coordinated Management of Meaning to give a deeper understanding of the event by collecting data through interviews. Furthermore, with this type of approach, the data from the interviews will support the theory and result in rich understandings and descriptions of the experiences provided (Bound, 2011). Phenomenology is a deductive approach that explores the theory and applies it to the interviews and then tests the research questions to gain a deeper understanding of the event. This particular way of looking at this research will allow the opportunity to describe the “world-as-experienced” by the participants to provide a common meaning (Baker, Wuest, and Stern, 1992) The seven interviews that were conducted for this study will provide a deeper understanding of the theory by revealing underlying behavioral patterns that are related to the situation of the research. This

analysis will provide an understanding of how the seven organizations coordinated and how the public responded to their actions. Lastly, this type of qualitative approach will reveal the phenomenon to which meaning is being attached. (Wimpenny and Gass, 2000, p. 1486).

Participants

To understand the participants selected, it is important to know about the organizations they were selected from. Seven specific organizations were first selected based on being part of the small community and the most significant organizations that played a key role in the community. The seven organizations that played a major role in the area include the: police department, local school, pharmacy, churches, county health department, city and state of Indiana. These agencies were selected because of the essential role they play in the city and in the way they affect the health being created in the community. The participants for this study included seven individuals that were selected from the seven organizations with convenience sampling. These participants included one individual selected from five organizations, two participants chosen from one organization, and one individual that represented two of the organizations. This type of sampling was used for selecting the participants because they were easy to access for interviews. The participants selected also play integral roles in their organizations. These participants have held positions within their organizations for a significant amount of time or were major contributors in creating the organization and providing quality service to the people that they serve. They were asked to participate in an interview for

these reasons and all agreed. All seven participants of the study were interviewed and asked questions in relation to their organizations understanding, connection, and action of the HIV/AIDS epidemic. Furthermore, these interviews speak to how the organizations responded to the public health crisis.

Interviews

Interviews were conducted with the seven participants to further explore and understand the health crisis within the rural community and how each of the seven identified organization's responded to the epidemic. The interviews were semi-structured meaning a list of questions were available but there was flexibility in how and when the questions were asked (Edwards and Holland, 2013). This allowed participants to talk about their own perspective and use their own meanings and ideas to develop their answers (Edwards and Holland, 2013). Each interview conducted was between 20 mins and an hour. The interviews were also recorded and then transcribed. The following describes how each agency decided to approach the HIV/AIDS epidemic in Austin.

Police Departments. The police departments that were involved in the area included: city, county, and state (see Appendix B). The Indiana State Police (ISP) have the resources available to take certain actions in the area that the city and county cannot provide. The state, county, and city officers are working closely together to help battle the drug problem in this community. The police are treating the HIV/AIDS epidemic from a law enforcement perspective by issuing a zero tolerance policy on any type of drug and targeting how drugs are being used and sold, not only by the dealers but by

doctors and pharmacists as well. From a law enforcement perspective, the needle exchange program is a nightmare because of drug users not safely disposing of the needles they have been given. They are throwing them out in yards, parks, and other local establishments. The burden of cleaning up these areas are then placed upon these officers, homeowners, and other state officials in order to keep the community safe from harm from these discarded needles. Dealing with the drug problem consumes the majority of the police departments' time.

Most of the crimes they handle, are caused either directly or indirectly from the drug problem in the community. The crimes they are continually investigating involve not only the possession of these drugs and paraphernalia, but also the other crimes due to the need to obtain these drugs which include the manufacturing of drugs, prostitution, theft, battery, and in some cases murder. Over the past five months, the police have been in contact with the FBI and DEA and have made significant strides in arresting several "key" individuals and drug dealers in the community. One of those busts included the arrest of a major drug dealer and several of his "dealers" under him. His area for trafficking drugs to this area included the Interstate 65 supply line from Louisville, Kentucky to Detroit, Michigan. This was an ongoing investigation by not only the local and state authorities, but by federal agencies as well, which were able to provide even more "specialized" techniques and resources that the local and state agencies do not have access to.

Meth is a highly addictive stimulant that is often produced illegally by these “home meth labs” that are popping up everywhere in small communities. Another more-increasingly known method used to make Meth, is called the “one-pot shake-and-bake” method, in which the ingredients are mixed together in a plastic soda bottle. Scott County has seen an increase in this method of making Meth recently because of the ease of use and its portability. There have been arrests made where people have had them in their cars, found in vacant lots and fields, and even in graveyards. The convenience of this method allows these “home drug cooks” to make their Meth anytime and anywhere that they want.

Churches. In some ways, the epidemic has brought organizations together and created kingdoms (see Appendix B). Many of the churches in the area have been working together and treating the issue from a spiritual side. Scott County, and Austin in general, is known for its abundance of churches. At one time, there were over 40 churches just in the small community of Austin. Many of the churches have banded together and have formed a group they call T4SC: Darkness to Deliverance (Together 4 Scott County). Every Monday night, they get together at a church and pick a different area of Austin to walk the streets and pray for those in need of spiritual guidance that are affected by this problem. Their goal is to bring hope to this community through love, support, and tools needed to those struggling with HIV/AIDS. Many of these addicts have witnessed to pastors, members of the church, group members, and counselors their feelings of desperation and hopelessness that they feel because of their addiction to these drugs.

According to their Facebook page, these prayer walk vigils are “takin’ prayer to the streets.” One of the churches has completely opened their church up to these individuals in need, and provide not only spiritual help but allows them to get help for these essentials they need and they call themselves Hope to Others Austin Ministry. This ministry started on Rural Street in Austin, known for its prostitutes and drug deals, in conjunction with the Backlot HOPE Ministry. Their ministry is focused on reaching those families in need and they provide counseling, mentoring, food, clothing, and hope to those in need from all walks of life. They have had many organizations approach them to provide recovery programs in the area and asked them to use their facilities to provide assistance to those struggling with addiction. They have worked with programs like center stone that is a community mental health and uses the building for a recovery and engagement center that gets people off o of the streets and gives them a safe place to go.

They also provide help to any that ask and do not force the help but make those with addictions aware of the resources that they have available to them. Additionally, the church has a women’s recovery program that gives counseling and help to women of addiction, who use sex for work, and experience poverty. This program is essentially open for anyone who is affected by addiction but appeals specifically to women and their needs in this epidemic. Additionally, they help women find other occupations, build skills, and help them learn about different types of protection for their health. Recovery meetings such as alcoholics anonymous and “Hope over dope” are provided from the purest project. The church also provides a program for their youth group once a week that

includes food and preaching. The church has not asked for help and all of these different programs have approached them to give help and provide resources to the community.

Local School. The local school in the area handled this issue by responding with an educative approach (see Appendix B). The school is providing resources to their students on the effects of drug abuse in their community. Local law enforcement agencies provide informational talks to individual classrooms during “question & answer” sessions that students may have about drugs they may come in contact with. The Indiana State Police provides educational assemblies for upper grade levels to inform them of the dangers of these drugs and the ramifications from using them. They also provide students with the knowledge of who they can talk to with any concerns they may have about these drugs. The teachers, staff, and administrators recognize the effect that these drugs are having on their students and their families. They don’t have an exact number, but through their own personal knowledge of these students’ situations and home life, they express that a many of their students are living with grandparents or other family members, are living in foster care, or living with family of friends or classmates.

An overwhelming amount of these students have also lost either one or both parents to either prison or death, because of the use of these drugs. The counselors that the school provides are overwhelmed by the number of students they must see each day because these students are facing obstacles at home that stem directly from the “fallout” and abuse of these drugs. The school offices are recording an unusually large increase of outside consultants from several national known agencies such as NYAP, CASA, and

DCS. There has also been an abundance and need for other specialized agencies such as school psychologists, therapists, mental health agencies, and youth advocate agencies.

Pharmacies. Another group affected by the drug abuse in this small community, is the pharmacies (see Appendix B). Meth has become a local problem for pharmacies because of one of the ingredients that it is made up of, Pseudoephedrine, which can be found in both OTC and prescription drugs (“DEA says new cold medicine can be used to make meth”, 2013). Over the last several years, pharmacies have seen more stringent policies placed on them whenever someone wants to purchase cold and allergy medicines that have the drug Pseudoephedrine in it. According to one of the local pharmacists, they are now required to keep these medicines behind their counter and if someone is purchasing one of the cold medicines, they must now show identification and sign for them so they can record how often someone is purchasing this medicine through a tracking database.

One of the local pharmacies in Austin has not made any changes since the health crisis has occurred. Before the epidemic, this pharmacy was serving two customers with anti-retroviral to treat their HIV. Additionally, the cost is very high to keep the anti-retroviral in stock. This pharmacy has continued to serve only a few customers because an additional pharmacy was opened up in the city’s only doctor office to offer medication to those who have recently discovered that they’re infected. The pharmacy has not made any changes or provided any additional help to the community to provide assistance to the problem. The needle exchange was going to be accessible through the pharmacies

until the county decided to set up the “One Stop Shop” for people to gain access to multiple resources other than just needles. However, this pharmacy has many drug users ask for needles and other types of equipment needed for intravenous drug use. Since this outbreak is primarily due to the drug Opana, this pharmacy stopped dispensing this drug. They decided to stop dispensing this drug because all of the other pharmacies in the area also stopped carrying the drug after the epidemic was discovered.

County Health Department. The County Health Department treated the epidemic from a health perspective (see Appendix B). The county health department was then in charge of running the “one stop shop” clinic and passing out the needles. They set up the “one stop shop” in Austin because the people needing these services did not have transportation or the ability to get to the nearby town, Scottsburg for these services. After this clinic was set up and started being utilized by those infected, the numbers leveled off and the state removed themselves from the situation. The department was very low staffed during this time and unable to provide the amount of services needed in a timely manner to the community. They were untrained on the needs of an HIV/AIDS epidemic and were unsure about how to approach many of the topics. Most of the employees went through HIV/AIDS training to learn more about the diseases. The CDC assisted the county with setting up the needle exchange and how to handle different situations associated with the public health crisis. The health department decided not to contact the Aids Health Foundation (AHF) for assistance with the needle exchange program. They decided not to work with the AHF because of the lawsuits that they were involved in and the reputation they have built from helping other counties obtain and manage needle

exchange programs. The counties that are working with the AHF have not been as successful in quickly gaining access to the resources that they need. However, Dr. Cooke's office decided to work with the AHF without the notification

The county health department had community meetings with stakeholders known as Health Policy Meetings. A coalition was created in the area called, Get Healthy Scott County Group. This group was designed after the very first health ranking came out, and Scott County was ranked as 92 out of 92. Essentially, this deemed Scott County as the worst county for physical and mental health in Indiana and the Get Healthy Scott County Group was designed to manage this problem. This coalition also has someone come to the health policy meetings because they're involved in improving the health of the community. These meetings were going on once every week, then once every three weeks, and then only once a month. Now, these groups have stopped meeting.

The media relations person helped them start educating the community on the issue because of the stigma that was being created. This was to explain how you can contract this disease and remove the rumors that were being created about the disease. For example, they wanted to make people understand that it is safe to eat at the restaurants and that you cannot contract HIV by using the same eating utensils. The county has also worked closely with LifeSpring, which is located in Jeffersonville, Indiana about 30 miles south of Austin. It is a community medical services organization that offers many programs that include: mental health and substance abuse services, in which, are two types of programs that are highly needed in the Scott County area.

State of Indiana. The state notified the county health department in early 2015 that an HIV outbreak was unfolding in the Scott County area (see Appendix B). The state subsequently also spoke with Scottsburg officials, another town within the county, however, they did not contact any officials from the city of Austin. The State of Indiana's Governor, Mike Pence, declared a public health emergency in March 2015 and set up a "one stop shop" in the county where people could come to the clinic to get tested, exchange dirty needles for clean ones, and resources to obtain proper identification such as birth certificates and drivers licenses, so they could apply for Medicaid.

Due to the state of Indiana omitting to contact the city of Austin or the Mayor, during the initial stage, many officials and those in authority, were not aware of the epidemic occurring in this area or even what actions that were being taken for their city and county. State health officials stated that they would work closely with the local health departments, health care providers, and others to help contain the spread of HIV in southeastern Indiana. These also provided disease intervention specialists to the area to interview each newly identified HIV positive individual to obtain information about their needle sharing and sex partners, as well as recommending care coordination services, medical care, and HIV prevention information ("ISDH: HIV outbreak in Southeastern Indiana", 2016).

City of Austin. The city officials of Austin felt that they were being left out of the loop because the state never contacted them about these epidemic issues that were going on in Austin (see Appendix B). They tried to combat the issue themselves by contacting

the Aids Healthcare Foundation (AHF) because they are an organization that is utilized worldwide to help with HIV/AIDS outbreaks. As the AHF became involved, they provided help to the community, Dr. Cook, who is the only physician in the city of Austin, had been working with Indiana University (IU) to help develop different ways they could target the issue and try to contain this epidemic.

Overview of Interviews. All agencies involved were trying to do their job and do their job well. It is clear that all of these agencies care and want to make a difference as this is exemplified in many of their efforts. There was much confusion and indecisiveness by all those involved about who was actually in charge of the situation. Each agency took their own approach, but what is not clear, is did the agencies coordinate any of their activities in order achieve a greater affect.

Results

After interviewing the seven participants, a thematic analysis was conducted and several themes arose from the data. A thematic analysis is “a process of encoding qualitative information” (Boyatzis, 1998). This process includes developing a list of themes that emerge from the data which similarities are discovered. “A theme is a pattern found in the information that at the minimum describes and organizes possible observations or at the maximum interprets aspects of the phenomenon” (Boyatzis, 1998). After the interviews were reviewed multiple times, the information was coded into four themes that include: coordinated response, uncoordinated activities, response time, and inadequate response. Understanding the nature of these themes will provide an

opportunity to understand the seven organizations coordination and the public's response to their efforts. In response to research question one, the levels of coordination were infrequent with the seven agencies. The response to the epidemic was slow, inadequate, and provided throughout various times of 2015. Each agency blamed one another instead of working together to figure out how each can provide the best response according to their own set of abilities and skills. Even with the sense of coordination that is occurring within and between some of the agencies, many are still lacking in some ways.

In reply to research question two, the public's response to the seven agencies efforts displayed that the lack of coordination and poor timely response to the crisis was not an effective approach in adequately informing the public. This is shown through the number of people infected with HIV in which reached 190 cases (Rudavsky, 2016). The public was not aware of the crises, therefore, they did not do anything until March of 2015 when the issue was communicated by the state to the public. The HIV testers saw an increase during this time of people getting tested. However, this HIV tester was not put into place until this issue was deemed an epidemic. The public was unaware of how or where to get tested and most could not afford this type of care. Currently, none of the groups are tracking any type of addiction or recovery rates to understand if the public is receiving effective help through the different programs being provided such as the one stop shop, needle exchange, and recovery meetings held at the churches.

Coordinated Response

The coordination that occurred between and within organizations were very infrequent and irregular. This coordination more typically took place within the subsets of organizations. Some managers and employees coordinated more often than seeking out what other agencies have developed to manage the issue collaboratively. The Indiana State Department of Health (ISDH) communicated the public health crisis to the county health department and informed them of the increase in HIV cases in the county and that they would take care of the situation. At a later time, the ISDH coordinated with the health department to come to the Scott County area to set up the “one stop shop.” The CDC and ISDH helped set up the shop in an old factory that was abandoned and the county health department took it over and modeled the shop after a similar shop that had been set up by the state when tornadoes went through the area a few years ago. This shop provided people the opportunity to get health insurance, participate in the needle exchange program, receive treatment, obtain a license, birth certificate, and more.

The ISDH provided many billboards and mailers sent out for the area that included information about getting tested, how HIV spreads, and more. They also provided a group to come into the local schools to educate the kids on the HIV outbreak. The program provided experts in the health field that put on a presentation for the student body and staff. They also helped with the health curriculum which has brought awareness and educated the students further on HIV. This program has also helped the staff be fully informed on the situations that many students could be living with at home.

The city, county, and state police have all been working together to battle the issues of drugs in Scott County. The state police took the lead on the project because they have the resources available to manage these types of problems. The DEA has also helped with bringing down some of the major drug dealers in the area. The people in the Scott County area that are arrested by city or county police are taken to the same jail. LifeSpring was brought into the jail and provided actual meetings with inmates to deliver adequate treatment. They're hoping that they can start utilizing the treatment Vivitrol, which is a shot that will help prevent cravings.

After this outbreak was declared, HIV Policy Meetings were being held between the Scott County Health Board, County Commissioners, Mayors, LifeSpring (a mental health facility), Get Health Scott County, Sheriff, Scott County Health Department, local doctors, and more who were getting together frequently to discuss how to combat this health crisis. The local hospital contacted the county health department to notify them that they were providing HIV core training and to teach people the basics of HIV. The county health department started meeting at the Clark county health department because it is part of the HIV Department in the state which included the ISDH, LifeSpring, the STD Department, and health officer. In these meetings, the Scott County Health Department gained an understanding of how all of these people who contracted HIV were connected and why it was spreading so fast. After gaining the understanding that it is an intravenous drug problem, and recognizing the mental health aspects, they wanted to work further with LifeSpring. They needed to get as many people into treatment as fast as they could. A media relations person was provided to educate the public on HIV, reduce

the stigma, and ensure they understand that it is okay to eat at the restaurants within the county. LifeSpring provided Scott County residents priority to their facility in the beginning of the outbreak in which would take one to two weeks to obtain their services.

Many churches within the area came together to develop programs and provide resources for those struggling with addiction and the families that are affected. One participant stated, “There have always been other churches that’s been helping us with our mission – and, different denominations. First Christian Church, Grace Covenant Church and just people who knew us and our family and friends – they kind of – they knew what we were wanting to do, what our vision and our goal is. And so coming together it’s just been like – it’s like a community effort” (see Appendix B). They have organized walks each week, where many of the churches come together to walk the streets and pray with those who want their help. In the Hope to Others (H2O) church, many have approached them to provide resources, donate food, money, pay bills, and offer buses to transport kids. A community mental health facility, CenterStone, contacted this church and wanted to use the building as a recovery engagement center that will get people off of the streets and providing a safe place for them to go and seek help whenever they’re ready. This church also offers different types of recovery groups each night of the week.

Uncoordinated Activities

The lack of coordination between agencies is evident with the poor response to the health crisis. Uncoordinated activities can be seen occurring between and within

agencies. Consider how the city of Austin has been begging for more funding for police officers and mental health resources for the last four to five years. The city of Austin felt they were being left out of the response process and decided to combat the issue themselves by bringing in the Aids Health Foundation (AHF). However, in the Health Policy Meetings that were being held by county officials weekly to monthly, they all collectively decided not to work with the AHF due to their current legal issues and the problems they were having with helping other counties obtain and manage needle exchange programs. This occurrence led to a turf war between many of the organizations because they all felt they were in charge over the issue. One participant stated, “There’s groups that think that they should be doing it and nobody else should have their nose in it or they think they should be in charge and nobody else should be involved unless they tell them they can be involved” (see Appendix B). In these meetings, all of the participants felt that their ways were correct and did not communicate in a way to understand how or who should take action. There is no dialogue between the Scott County Health Department and Austin about what each are doing to manage the HIV problem. The Scott County Health Department felt that they were “probably” the lead on this epidemic since it is a public health issue. They wanted other agencies to treat this epidemic in the same way. They also had issues with staffing as the administrative assistant and multiple HIV testers have quit.

The State of Indiana did not take action on this matter until the middle of March whenever Governor Pence received a certified letter stating that the county was in need of help due to the severity of the health crisis. One participant stated, "The State never

contacted the City of Austin, the Mayor, until they were forced to do so, but you would have thought the Mayor would be the first person you'd want to be involved" (see Appendix B). Also under the pressure of national and state public health experts, Governor Pence signed an emergency measure to establish a needle exchange in Scott County in which provided an opportunity for other counties to start these programs as well. The state did not provide any type of funding or assistance for the needle-exchange program, they threw in a one-time program at the local school, and helped with some media relations. Their involvement has been brief and minimal to reduce their interaction with the needle-exchange program and has required Scott County along with many other counties struggle to get a program like this due to the costs and resources required.

The state of Indiana only has a few HIV departments in the state and Clark County manages 16 counties alone. With an epidemic that has reached astonishing numbers in one small county, what do these other counties look like? How is one department supposed to manage this amount of testing of the population especially during a public health emergency? Since Clark County has always been managing these counties, Scott County's public health nurse was never aware the amount of HIV cases the county actually had. In the beginning of the epidemic, there was no location in Scott County for residents to get tested after the closing of Planned Parenthood. Many were approaching churches asking to be transported to nearby cities to get tested and to be taken to mental health facilities for treatment. Many people of the congregation were confused and uneducated about HIV and how it can actually be transferred.

Understanding this Appalachian-like culture was a challenge to manage with the issue as

well. The stigma of HIV in the community was developed by people who were uninformed about the effects of HIV. LifeSpring provided an opportunity Scott County residents to help them seek medical attention as fast as possible. However, LifeSpring is still a 40 minute drive to Jeffersonville in which is no help to those who do not have access to transportation but it is still the closest inpatient mental health facility. Since the numbers have leveled off, LifeSpring has not made residents Scott County a priority and they're back to waiting 6 to 8 weeks to receive medical attention for mental health problems.

The police have not collaborated their activities with other groups because they're the ones picking up dirty needles, seeing the expansion of the health crisis turning from Hepatitis C to HIV due to intravenous drug use, and losing faith in the purpose of rehab centers. They have no way of tracking who's an addict, what drug they are using, or what drugs they have been addicted to. They have probably been managing this health crisis the longest in which has led to their lost faith in the health system. A hepatitis C issue was occurring for a long time in the area due to drug use but it wasn't brought to light until the stigma of HIV caused an uproar. The police have felt little help from the health department in the past because now they have to deal with this issue from a health perspective but have been trying to manage it for years from a law enforcement perspective.

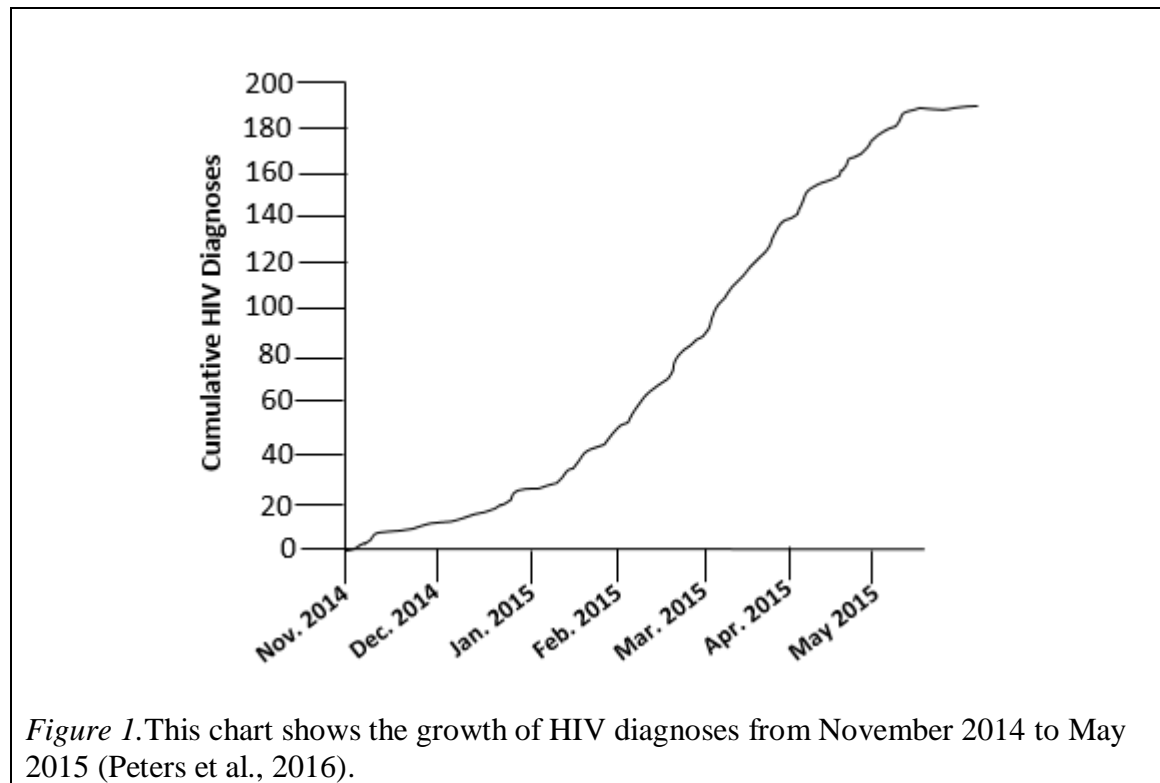
The state and the school did not coordinate on how to address the students and what type of information they might need from the state. Many students in this area live

with grandparents and have someone in their immediate family in jail. They feel that the state has people come in with good ideas but the execution of these ideas are lacking because of the demographic of students needing this is not applicable for them due to their circumstances. Students need the opportunity to have better healthcare, for example, many can't afford dental care and can barely get a physical to participate in extracurricular activities. They also don't have means of transportation to obtain these opportunities.

One of the pharmacies in Austin has not dealt with most of the HIV patients so they're unaware to where they're obtaining their medications. This pharmacy hasn't started seeing any new HIV patients and assume that the new pharmacy that has opened up for this public health crisis is taking care of all of those infected. The ISDH and Scott County Health department approached one of this pharmacy in Austin to ask questions about their experience with the public health crisis. This pharmacy also stopped dispensing the drug Opana when they discovered all of the other local pharmacies had stopped providing this medication to customers. No one actually told them to stop dispensing the drug, they just thought it was the right thing to do since the other pharmacies stopped selling them. None of the pharmacies attend the Health Policy Meetings.

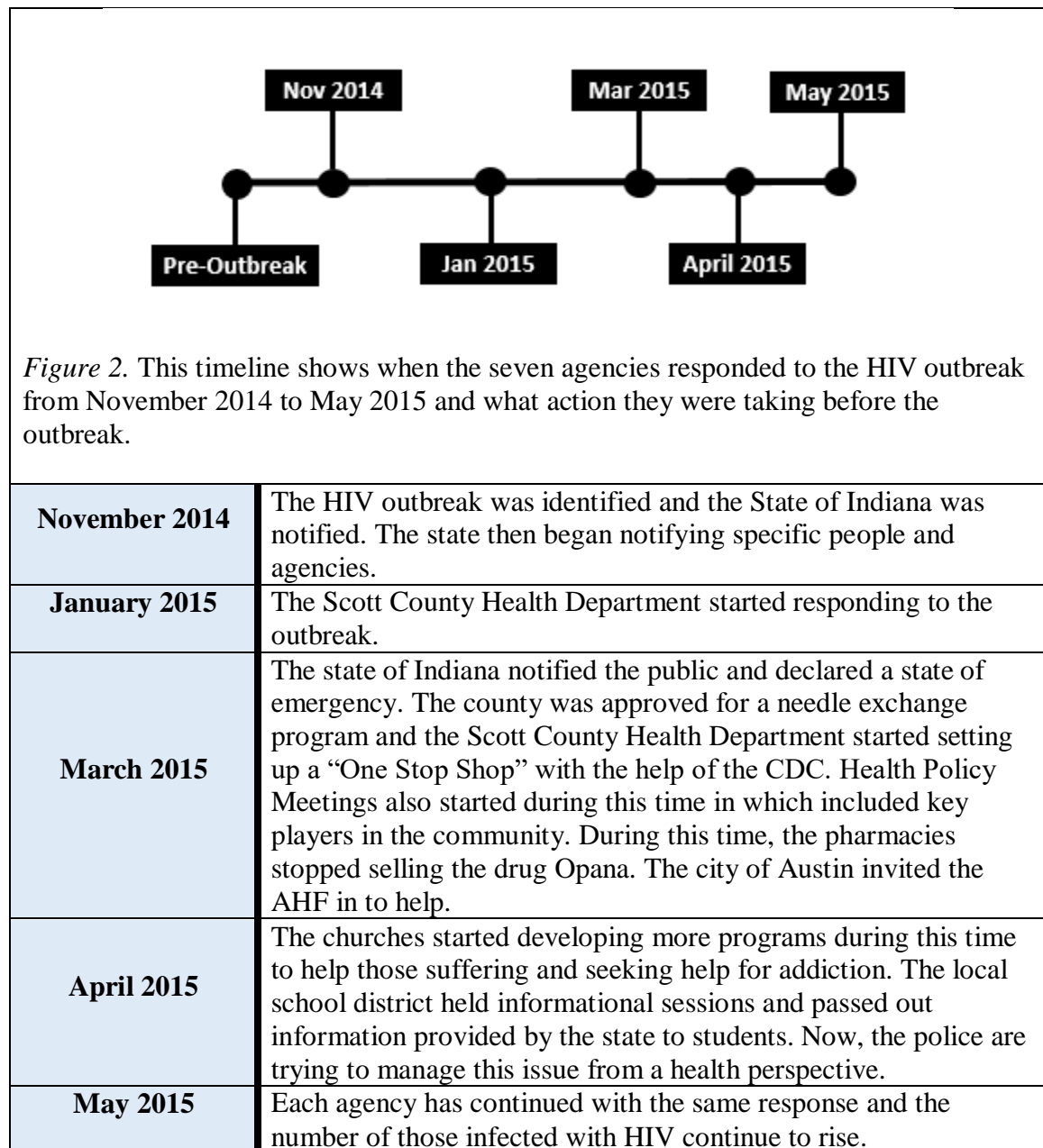
Response Time

The following figures show the timeline in which different agencies responded to the crisis.



The State of Indiana did nothing until the epidemic reached 80 cases and was gaining media attention. An epidemic and health state of emergency was declared in March of 2015. In reference to figure 1, this response time was too late as the increase of HIV diagnoses was reaching the high 80s. The city of Austin had been begging for help with resources, funding, and access to health care, etc. before the crisis occurred and during the outbreak. The churches knew that drug addiction was a problem before the epidemic was declared and had tried to implement recovery programs but none of the

programs took off. When the epidemic was reported, many of those that were recovering in the church discovered that friends they had previously been spending time with were HIV positive and were concerned.



In reference to figure 2, before the outbreak was discovered, the police was trying to manage the drug problem of Opana. They believe the Opana issue started when they

were able to cut off the access to meth and other types of drugs. By November 2014, the HIV outbreak was identified and the State of Indiana was notified and notified specific people and agencies. The county health department started responding to this health crisis in January of 2015. In March, gatherings were called for Health Policy Meetings once a week to develop a plan of responding to the issue. The county health department was already aware of the intravenous drug problem due to the spread of Hepatitis C and it is a problem they have been battling for a number of years. They understood the severity of issue and brought the CDC along with other experts in quickly to help manage the epidemic. The school did not get involved in responding to the problem until the epidemic was in full effect. Different programs, speakers, communicative items, and counseling was provided to students and open to the public for use. The pharmacy really wasn't aware of the magnitude of the situation until HIV testers were brought in to start testing those that could potentially be infected through intravenous drug use and prostitution.

Inadequate Response

An inadequate response to the epidemic is evident as the agencies' response times were significantly slow and uncoordinated. The state did not respond to this issue until March of 2015 when the numbers of HIV infected people were rising in late 2014. They provided funds to hire one nurse for the county and did not want to have a hand in the needle exchange program. The city of Austin was not contacted by the state to let them be known of the health crisis that was occurring. The city did not provide any response

until they contacted the AHF for their assistance. However, the county health department and other agencies had decided not to work with the AHF due to some issues the AHF is experiencing.

The police are continuing to address this problem from a law enforcement standpoint. It is difficult for them to see the positives of the needle exchange program when many are just throwing the needles out and it has been placed upon the police to pick up these needles. One participant stated, “Instead of exchanging them, they’re just throwing them away. They’re throwing them out there everywhere. And we’re not only seeing that here, but we’re also seeing that in other places where they’ve got needle exchanges that have started” (see Appendix B). The county health department has struggled because they had to learn very quickly about HIV and what to do with an epidemic of this caliber. A significant issue they need to figure out for residents is transportation to get people to the resources they are in need of such as health care, support groups, and mental health facilities. They’re also lacking in substance abuse treatment options, the soonest they can get someone in for treatment is a minimum of two weeks and at least a 25 minute drive. Another participant stated, “One of our biggest fears, obviously, is that people aren’t going to get treatment.

The school feels that many of the programs and information that has been provided to students has not been applicable to all students. The presentation given by the state was presented to the entire student body which provides a wide range of ages. For example, many of the elementary students struggle with understanding this situation and

many of them have parents who are affected by this epidemic. However, the program that the state provided was not adequate for all students and does not allow them to be appropriately informed. The church feels that not enough is being provided to the children. They believe the children are being overlooked and not provided the help they really need for this epidemic.

The pharmacy has not provided any extra information to their customers or the community about Opana, intravenous drug use, or HIV medications. Before the epidemic was declared, they already had a few customers obtaining their antiretroviral from them but the amount of customers never increased after many people in the community discovered this disease. The antiretroviral medication is very expensive to keep in stock in which is challenge because customers have to call days in advance to ensure the pharmacy can obtain the medication in the right amount of time.

Discussion

What did we learn from this case study regarding health systems response and resiliency? An understanding that health crises need to have agencies that collaborate to provide coordinated responses that are effective in managing these issues. The issue with the seven organization's response to this health crisis is that they were all disconnected and responded to the issue separately. These silo-like responses from organizations created a way for them to react in uncoordinated, in which, caused a response that was slow and inadequate. This study found that uncoordinated-like activities occurred the most frequently between agencies and led to an inadequate response. For example, one of

the ways in which uncoordinated activities of agencies occurred was when the city of Austin decided to work with the AHF and the other groups that had been meeting collectively decided not to work with the AHF due to prior issues of managing needle exchange programs. Another sense of being uncoordinated-like activities is that all seven organizations took their own approach to the matter without understanding how the issue is already being managed.

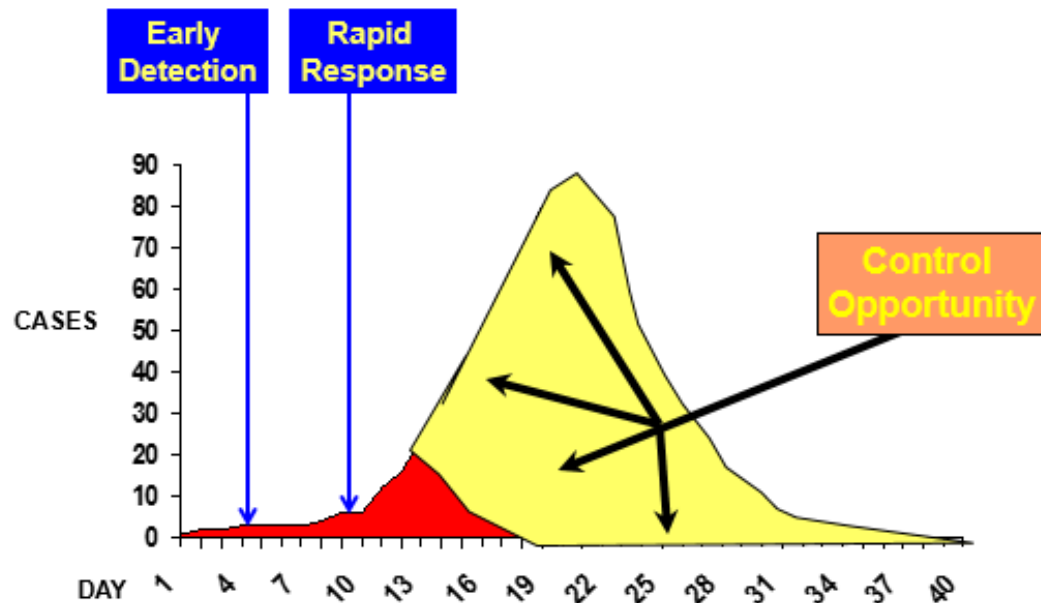
Additionally, from the results emerged the understanding that to the extent that coordination occurred in this case, it was mainly between subsets. For example, the church and the Scott County Health Department had the most coordination within their organizations. The church was regularly organizing different support groups and providing resources for those who needed their assistance. The health department was creating a “one stop shop”. The health department did coordinate some with the CDC and the state to receive help setting up because they had never had to manage an infectious disease at this level before. Furthermore, when the state of Indiana learned about the health issue in the county, they held onto the information and only shared with a select number of groups. They didn’t start trying to create a sense of coordination until months later when they were forced to react when the amount of people diagnosed reached epidemic levels. The silo-like activities that were carried out through all of the agencies created the lack of coordination in which led to such a disastrous response.

The response provided by the agencies was inadequate because of their uncoordinated activities and due to the public’s response to the crisis. The numbers of people getting tested have leveled off and the numbers of people infected increased

drastically within a few month period. Would some of these people not be affected if the state of Indiana had informed them in fall of 2014? There is currently no way of tracking recovery rates or knowing how many of those are seeking and receiving the help that they need. The public's response indicates that the agencies approach was ineffective to the crisis.

The response time to the health crisis was nothing short of a disaster. When the state of Indiana was notified about the rising number of cases within the area, they should have immediately developed a plan to strategically release the information to the organizations and public to help prevent the spread of this infectious disease. According to Odugleh-Kolev, the following graphs illustrate how a timely response can provide an effective or ineffective response to a health crisis (2016). An early detection provides a rapid response and an opportunity to control the issue. When a late detection occurs, a response will not be provided until later and the opportunity to control the situation will be at a much later time.

A. Rationale for early detection, assessment and response



B. Rationale for early detection, assessment and response

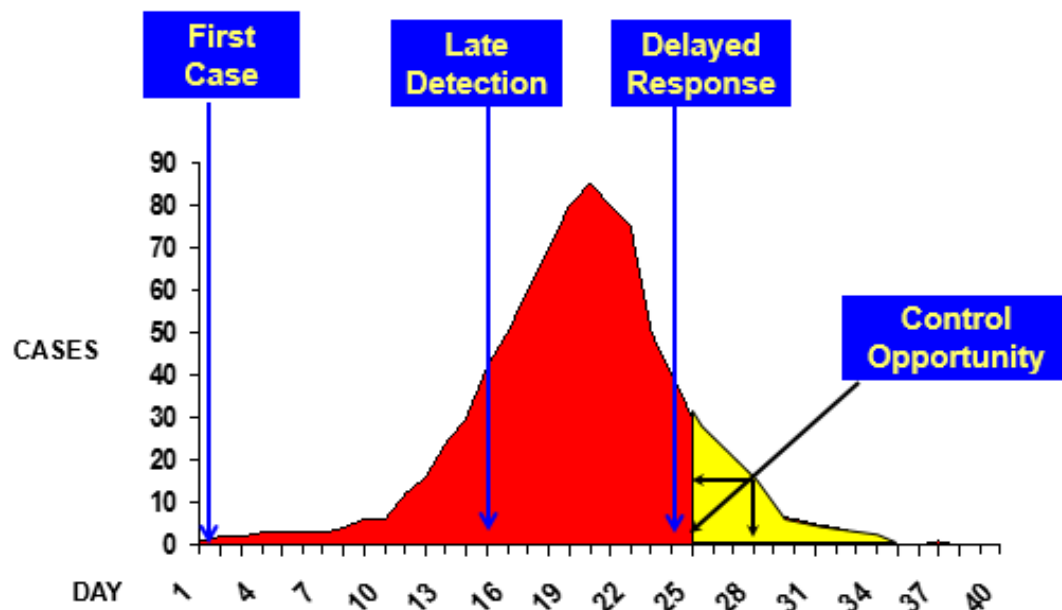


Figure 3. Early and Delayed Responses to Health Diseases

Panel A shows the number of cases of a disease and the better opportunity to control the outbreak if it is caught within the beginning of the first 10 days.

Panel B shows the number of cases of a disease and the inability to control an outbreak until the last 30 to 40 days when late detection occurs. These graphs are adopted from "Communicating Infectious Diseases Risk in a Dangerous Decade," by Asiya Odugleh-Kolev, 2016.

In figure 3, the graphs illustrate how responding to a disease outbreak slowly can be detrimental to the opportunity for controlling how the issues are managed. In reference to panel A, when agencies respond rapidly and in coordinated ways to an issue, the opportunity to control an outbreak occurs sooner. In reference to panel B, this graph is comparable to how the response occurred in Scott County. The late detection of the epidemic and delayed response left an inadequate amount of time to provide the most effective way to manage. Without a timely response, lack of coordination, and the late detection, this health crisis had no opportunity to provide a response that would adequately provide the resources needed in the amount of time that was required. Now, consider the response that could have been provided by the seven organizations. If these agencies would have coordinated, they could have provided a rapid response that would look similar to panel A. They would have then been able to provide a response that was more controlled and well managed at the beginning of the epidemic instead of at the end.

Furthermore, the timeline in which they responded provides an ineffective approach to responding to this epidemic. These issues are only manifestations of a set of systemic health problems. The responses given were only putting temporary or minor fixes on a system where people still don't have jobs, massive mental health issues, and do not have the amount of educational support needed. The issue with these organization's response to this health crisis is that they were all disconnected and responded to the issue

separately. The problem with organization's being in "silos" and reacting in uncoordinated ways caused a slow response time and an inadequate response. The agencies in Scott County do not communicate and if they do, it is very infrequent and ineffective in which leads to them being uncoordinated. The response given is a completely inadequate response to a holistic systemic problem. Nothing is being done to engage members of the community to figure out how this health crisis should be handled.

Health crises can be managed but it is essential to discover how they occur in the process of the issues unfolding, and to gain a better understanding of how to approach the issues from a communication perspective. Communication for Whole Health suggest that the importance of conversations being created and are imperative for developing coordination between agencies. Applying a CWH perspective to a public health crisis such as the HIV/AIDS epidemic in Scott County would help create a supportive health system that is resilient (Parrish-Sprowl and Parrish-Sprowl, 2016). For example, on an international level, consider the Ebola outbreak in West Africa. It was one of the most devastating health crises and created panic that had real human consequences. The lack of a public health system led to the inability to effectively respond to a crisis of this caliber. The level of leadership needed was lacking and the ability to provide a rapid response to manage the issue from spreading out of control was absent (Moon et. al, 2015). On a local level, the HIV outbreak that occurred had the same issue, there was no sense of a health system. This lesson was on an international scale and now on a local scale but we are still not learning from it. Understanding that whether it is on an international or local level, we are systemically connected and infectious diseases can occur anywhere (Global

Ebola Response: Late, Feeble, and Uncoordinated, 2015). Before the HIV epidemic occurred in Austin, this area was already lacking in health resources, education, and care. This community was already disconnected before the epidemic and the significance of disconnection was shown when the amount of those affected were established. How can any area provide a healthy environment when they are significantly lacking in resources that would induce a more health oriented society? It is imperative that agencies start working collaboratively by coordinating their resources to provide rapid responses to health crises and give the opportunity to produce a physically and mentally healthy society.

From a CWH perspective, these agencies are not learning from their past conversations that have created and co-created their realities. These areas would benefit by taking a CWH perspective and analyzing what is going on between the agencies, public, and leaders of the community. Austin would benefit from a CWH perspective because it would contribute to building a health system that is resilient and provide an understanding of how the current system is lacking by others not being coordinated and contributing collaboratively (Parrish-Sprowl and Parrish-Sprowl, 2016).

Communication is a systemic process that people interact to create and interpret meanings and symbols. Utilizing CWH to develop health systems is one communicative approach to managing health crises, understanding public health, and developing resiliency (Parrish-Sprowl and Parrish-Sprowl, 2016). This would be the most beneficial way to address Austin and their health issues as it would give them an opportunity to develop a new way of managing their health. Working as a whole health system would

mean creating community focused primary care that would help overcome the limited resources including the deficiency of health care providers and personnel (Maeseneer, et al, 2008, p. 518). By strengthening primary health care, this would strengthen health systems, through investing in human resources, health education, and improvement of infrastructure (Maeseneer, et al, 2008, p. 519). This would require coordination between all agencies including: government, non-government, religious groups, and other contributors (Maeseneer, et al, 2008, p. 518). “This will allow all diseases to be prevented and treated in a systemic way” (Maeseneer, et al, 2008, p. 518). This will also allow for the opportunity to access better routine care.

“If the government took full responsibility for developing policies that ensure the necessary resources to establish a comprehensive national health system and health-promoting environments regardless of which jurisdictions, sectors, or organizations are providing health services” (Stumberg, O’Halloran, and Martin, 2012, p. 827). By creating this type of health system, our health systems would be person-focused and have the ability to address individual needs, be flexible in structure, and uphold a well-qualified health workforce that has the ability to provide the appropriate services when and where they are needed. This would allow for local health systems to be interconnected that would promote healthy environments in communities. More specifically, this would spread across occupational, social, and natural environments (Stumberg, O’Halloran, and Martin, 2012, p. 827).

CWH would provide a system that is resilient and agencies would have a process in which they would coordinate, connect, and consistently work with each other to

execute ways of promoting and living out better physical and mental health (Parrish-Sprowl and Parrish-Sprowl, 2016). They would have the ability to provide an adequate and timely response that would be conducive to managing the problem. These resilient systems have the capacity to maintain core functions if an issue occurs and reorganize to manage the issue. For human life they provide protection and are able to produce good health outcomes when a crisis transpires and within the aftermath of the situation. A resilient health system also delivers positive health outcomes and everyday benefits.

A resilient health system response to the HIV crisis in Austin would call for a well-functioning, proactive healthcare delivery system and one that provides a strong public health response. During a crisis, these two systems must work collaboratively and be able to fully function before the crisis occurs in order to have a better outcome (Kruk, Myers, and Varpilah, 2015). “Healthcare systems are complex adaptive systems and resilience is an emergent property of the health systems as a whole rather than a single dimension” (Kruk, Myers, and Varpilah, 2015). Consider the Ebola epidemic and how a resilient health system was significantly lacking to help manage the issues. This shows how health crises are being experienced all over the world and it is imperative to build public health systems that are resilient and can provide a coordinated response to health emergencies. This system should also be established with healthcare professionals and personnel who have the knowledge and ability to provide everyday care along with responding to a health crisis. This type of system will help develop a community health system because it will provide community members and agencies in the community to

create a sense of trust, support, and community engagement due to the high-quality services (Kruk, Myers, and Varpilah, 2015).

Conclusion

This study sought to understand the nature of agencies coordinating during health crises and how the public responded to the efforts made by the organizations. The main findings of the study discovered some coordination, a poor response time, an inadequate response, and uncoordinated activities that occurred within and between the seven agencies. Many of the agencies blamed each other instead of coordinating their efforts to provide a well-developed response of their expert skills. The public's response to the agencies efforts was poor because of the lack of coordination and poor response time. The number of those infected reached 190 cases because the public was not informed until March of 2015 when the epidemic was first discovered in late 2014.

If agencies coordinated during public health crises, they would have a better opportunity in managing the issue in a more effective manner. If a resilient public health system was in place, one could argue that the number of HIV cases would've been significantly lower around 5 or 10 instead of reaching almost 200. Real human consequences were acquired from this crisis, and the CWH perspective approach to a health crisis would provide an opportunity for better coordination and an adequate, timely response.

For taking a CWH perspective, we find that providing systems that are resilient will provide communities that are engaged, collaborative, coordinated, and functioning in

a way that promotes physical and mental well-being. This type of system has the ability to reduce loss of life and provide effective care for crises and routine health needs.

“Resilient health systems can also minimize social and economic disruption that characterize outbreaks and other large-scale health threats by engaging people as partners in containment efforts, reducing fear, and hastening resumption of normal activity” (Kruk, Myers, and Varpilah, 2015).

The approach that many agencies provided for this public health crises shows that Indiana doesn't take healthcare serious. More specifically, it shows how the State of Indiana doesn't provide the amount of support needed for counties to be healthy. Scott County was ranked 92 out of 92 counties in Indiana for health even before the HIV epidemic occurred. The suggested communicative implications will provide an adequate response to the coordination of agencies for public health crises. Additionally, if Austin chooses to start applying many of these ideas, the public will be well informed and organizations will have a sense of direction about how they can provide a positive response to a health crisis. Taking a CWH perspective's design, construction, and execution of resilient health systems is deeply beneficial to effectively managing health crises and building healthier communities.

The major limitation to this study is not so much who was interviewed, but the organizations that were missed. For example, there are three pharmacies in the Austin area but only one was interviewed to understand their experience with the HIV/AIDS epidemic. The one doctor in the Austin area and closest hospital in Scottsburg were not

interviewed for this study either. We may learn something else about responses to health crises if everyone involved was interviewed but what would we learn? Would it be more or the same understanding that has already been concluded about the common responses provided by the other organizations? Some further questions that were raised include: how is the lack of coordination affecting organizations and associates? What kind of stigma has been created from this health crisis? How are organizations communicating to customers that they are providing a safe and clean establishment? For future research, the same participants could be interviewed to understand how the agencies are now responding to this crisis. Are they responding the same? What is the stigma like? What do they think they could have done differently to avoid this health crisis? What are they doing now to prevent this from happening again? How are they building better health systems in the community?

Understanding the drug issue in Austin, the HIV/AIDS outbreak, and the overall health issues being experienced in the area provided valuable insight into how this area is suffering from a poor health system. This study showed how imperative it is for agencies to coordinate their efforts provide an effective response to health crises. This can successfully be accomplished by implementing communication for whole health, meaning health systems will be resilient and have the ability to manage any type of health issue or crisis that will be experienced by the community. Communities would have the opportunity to provide care for everyone and the ability to deliver a timely response that would have a sense of coordination and collaboration.

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Appendix A

INTERVIEW GUIDE

1. Can you talk about the HIV & AIDS epidemic in Scott County?
2. What is going on in Scott County with HIV & AIDS?
3. What action is the (City, State, & Community) taking for this epidemic?
4. What could they do differently?
5. What problems is the community facing?
6. What affects have these issue had on the community?
7. Before this epidemic occurred, what was (City, State, & Community) doing to understand HIV & AIDS?
8. What should organizations be doing here that they are not doing?
9. What happened in this circumstance?
10. Is there anything else you would like to add?

Appendix B

INTERVIEW TRANSCRIPT

Interview 1

Interviewer: Go ahead.

Participant: So the first HIV cases were popping up sometime in late December. So we were in Legislative session – I think it was about the middle of January, the State Department of Health contacted me and wanted to know – you know, just come to me and said “Hey, here’s what’s going on down there. It’s going give you a little insight in case, you know, the word gets out and news media gets a hold of it, starts talking to people and all that.” So I said “okay, I appreciate it.” So the State really – they just kind of monitored it. They didn’t really come do anything until like it reached 80-some cases. That’s when the State - that’s when the Governor decided to declare it as an emergency. It was like in the middle of March sometime.

Interviewer: Yeah.

Participant: Sometime in the middle of March, he declared it as an emergency. They’d come down and there’d be a press conference. He announced that the State would come in and set up this one-stop shop where people could come by and get tested, they could get free needles, they could get their birth certificates, driver’s license and all the vital statistics stuff you needed to get a driver’s license and be able to get Medicaid. And actually what happened was the County then had to approve the needle exchange program before the State could help pass those out. And the State didn’t pass them out. They said, well, the County Health Department has to be the one to do that. The State couldn’t do anything like that. They wanted to keep their hands clear of it. So then, what happened in the meantime when all of this was going on, and the County Health Department was in charge of county health, obviously, and they had been in contact with the State. The State never contacted the City of Austin, the Mayor, until they were forced to do so, but you would have thought the Mayor would be the first person you’d want to be involved as well because I would thought if this was happening in Marion County, they wouldn’t have let Greg Ballard out of the loop in the County.

Interviewer: Yeah.

Participant: So, at this point (INAUDIBLE) the State – actually we went round and round about a few things. So they set up the one-stop shop. They came through and finally it leveled off. What is it? 110, 104 somewhere it is. So, now the State, they’ve pulled out. They’re giving the County money. In the meantime, the County has been

working with and having community meetings with stakeholders, which with the Mayors, Austin's counselor (?), the County Commissioners, those folks – those meetings were going on once a week at one time and then went down to once every three weeks and then once a month, and I don't know if they're meeting anymore or not. So, the communication basically was a top down communication. It was coming from the State and filtered down to the County Health Department, and then whoever the County Health Department wanted to let in on what was going on and they sent that information out to who they felt necessary. So...

Interviewer: Okay.

Participant: In the meantime, the City of Austin decided they were going to – since they felt like they were being left out of the loop and most of it was going on in Austin, they started their own – tried to combat it themselves. Mayor Campbell contacted the AHF group, AIDS Healthcare Foundation group, to come in because they're the world's largest AIDS healthcare group worldwide. And the model they used are what's being used by groups and so they came in and in the meantime IU was working with Dr. Cook. And then once it started stabilizing, folks started getting a little contrary with each other. All of a sudden a turf war sprung up. This group said they were in charge and that group said they were in charge, the County said they were in charge, and really what happened was nobody became in charge. It kind of a general mess. The County continued to do what they were doing, the City did what they were doing, the State did nothing – they just gave the County money, which they're doing now. So that's where it's at today. I think the model they got today is the State of Indiana is giving the County \$50,000, or something to be able to help hire an extra nurse. So that's the extent of the State's offering.

Interviewer: So that's the only funding they're giving?

Participant: Yeah.

Interviewer: Okay.

Participant: It's been a joke.

Interviewer: Yeah, it's bad.

Participant: They've just been bad. They've been terrible, awful. What really gets me is the fact that the City now is involved in it. The City has been begging for help for police and help for mental health groups to come in for the last four or five years, Mayor Campbell has. It wasn't until I sent a certified letter to the Governor, to the Health Commissioner, to the local – all the locals – everybody got the same letter, addressed to the Governor, stating that we need help, you need to come down here, the HIV thing's hit. It wasn't until after he got that letter, whenever that was, the middle of March, that

the State did anything. So, between December and March, the State just kind of monitored it and didn't come in.

Interviewer: Um hmm, just let it go.

Participant: They just felt like, I don't know what they did. I don't know if they felt like it wasn't their problem or they felt like it would go away or if they stuck their head in the sand it would pass over them and the sun would come up tomorrow. But obviously it didn't. And the reason I sent it certified was so I could verify and prove that they received it because if you send certified mail they have to sign for it. So, that's why I sent it certified. That way if they didn't do something, they couldn't say "well we didn't get the letter – what are you talking about?" So that's why I did that. I sent it certified to the State House.

Interviewer: Okay. So, what other problems do you think that you may be facing then from this?

Participant: Well, I think the long term problem is going to be the stigma that the County is facing, that's not just the City. It's going to be the stigma of being in a place where there's sick people. Whether that's fair or not, that's the way the media has been here. It's no secret. You're from Scott County, the first thing people do is ask you about the AIDS epidemic, you know. So, it's unfortunate because I think that's going to stay with the County. The County of Scott is not the only surrounding county that AIDS is there. It's in Clark, it's in Washington, it's in Jackson County. You've got a county that's a little smart – their smart enough to realize that, hey, we don't want this to get out because we'll have the same stigma that Scott County has got now. And I think there's going to be a long-term effect. I think people will think twice before they do business in Scott County, and I think they're already doing that, and it's unfortunate.

Interviewer: Yeah.

Participant: So, what I've asked the State – I stepped in and asked the State of Indiana to come down and help out. I've asked the State of Indiana to have a presence here, whatever presence that may be, whether it be office workers or whatever, to show that the County, you know – you don't have to put a big rubber glove around Scott County, it's safe to be there, you can eat in the restaurants just like you can everywhere else. And probably one of the positives that came out of this – you can't even consider it a positive other than it's a learning experience – the fact that I think people finally realized that AIDS wasn't a death sentence anymore. The people live with AIDS now, they live a healthy lifestyle. As a matter of fact, they take medicine and it all but evaporates the virus. The virus is no longer in the system. I think probably more than anything, it's been a learning experience. Most folks realize that hey, if you get AIDS or catch AIDS, and it's not a death sentence.

Interviewer: Okay.

Participant: I think what it also exposed on the bigger ground for the State is the drug crisis, and that crisis is obviously just not in Scott County. That drug crisis is not just in Indiana, it's nationwide and it's because there's a lack of hope and a lack of structure. People can't get ahead and until the nation decides economically we're going to step up and start giving people a fair wage, like passing the minimum wage – until we decide that we're going to start giving people mental health care instead of trying to put them in a jail somewhere, until we decide that everybody counts, you know, everybody's life matters, until the nation and the State of Indiana decide that, we're going to continue to struggle like that. This is going to be not just in Scott County, it's going to be, like it has already, up in Connersville, it's going to be in Fort Wayne, it's going to be in all these other areas the same way. So, the difference is that the areas up there know how to handle it a little bit better because of what took place in Scott County. And the first thing they'll do is they'll know not to publicize it. So they'll try to hide it and they'll try to treat it secretly or under the radar.

Interviewer: Right. Okay. So, how do you think that the crisis has affected different organizations within the County?

Participant: You know I think in some ways it's brought organizations together and in some ways it's created kingdoms. I think the churches have decided that they want to work together and I think the church groups have gotten together and work great together, no doubt about it. The County Health Department who has been in charge, they're doing the best they can. But what you've got to realize, the State of Indiana doesn't take healthcare serious because the Commissioner, the Indiana State Health Commissioner, is a part-time job, it's not even full-time employment. The local offices are funded penny only – there's hardly no funding. So, and that's what I said, until we start providing opportunities for people to get help instead of trying to throw them in jail somewhere, you've got to provide mental health care and it's going to be a struggle. And the problem is that the groups – like the Health Department – they're going to try to treat the problem from the healthcare side. Well, the Sheriff's Office and that group of people, they're going to try to treat it from law enforcement side. The church people are going to try to treat it from a spiritual side. So what you've got is you've got all these different groups trying to treat it the way they think - the only way they know to treat it. And that's fair, that's what they should be doing because that's their expertise. But the trouble is, is that they're not willing to come together – it's almost like happened like a turf war.

Interviewer: That makes sense.

Participant: There's groups that think that they should doing it and nobody else should have their nose in it or they think they should be in charge and nobody else should be involved unless they tell them they can be involved.

Interviewer: Okay. Anything else?

Participant: No, I think really the ramifications of this won't even been seen until four or five, ten years from now.

Interviewer: Yeah.

Participant: Because, I mean, ultimately the spread of it has stopped, but what they don't know is how many hundreds of people that they have kind of verified that came into contact in a way that could have spread the virus – hundreds of those people came into contact with these folks. Out of those hundreds, I don't even want to say a number now because it's – I think it's 600 or 700 people that they've actually verified. I don't know the actual numbers. But out of those, a lot of those folks refuse to be tested and a lot of those folks they couldn't find.

Interviewer: Okay.

Participant: Out of that hundred – could be possibly up to a thousand people – and it's not people – really, the only people that they've identified and located and the people that wanted to be tested was probably the people that couldn't get help anywhere else and was on their last leg. Because they said, okay, what can I do? The other folks said, I'm don't want this to be known. I'm going to try to hide it. We have to do something different. And whether that's they live in Louisville or they live in Indianapolis or Seymour or wherever. So those people either refused to be tested or they couldn't find them. That's going to be the real issue; okay, where are those people? We know that they frequented a house where they were shooting up and passing a needle around. So the people in this house were HIV positive, and specifically hepatitis C positive, which is what the real issue is nationwide and statewide. Okay, we know they've been there, we knew they were there doing that practice and we know they were sharing needles, so chances are they've probably got HIV but we can't find them. So I don't know how many hundreds of those people there were.

Interviewer: That's pretty crazy. Anything else?

Participant: No, nothing I can think of. If there anything specific you can try to think as you're writing it, you can call me or text me.

Interviewer: Okay.

Participant: It's unfortunately to think that out of the entire United States of America, it's a big country, 300 million plus people, that an outbreak took place in Scott County.

Interviewer: Yeah it is, and it's known internationally.

Participant: So that's the unfortunate part because the stigma that I talked about earlier. It's going to be very difficult for the county to overcome this stigma-wise. Some folks want to think it's maybe just an Austin problem or whatever, but it's not, it's a county problem. At the state level, they don't talk about Austin, they talk about Scott County. And then when you see it in the New York Post, they're not talking about Austin, they're talking about Scott County.

Interviewer: Well, it seems like people here, though, talk about it as Austin.

Participant: It is, but that's one of those deals where you've got people who want to ignore, don't think it's happening in their area. And even the people in Austin, if you hear them talking, they'll say, oh, it's on the north end. So nobody wants to own, so they just keep pushing it somewhere...

Interviewer: To other locations.

Participant: Yeah.

(END OF INTERVIEW)

Interview 2

Interviewer: Go ahead.

Participant: When it first happened, of course the epidemic came out, the issue was it was a medical issue where they were using dirty needles and they came in and just started handing out a lot of needles. We are now feeling the effects of that because we're picking up needles everywhere.

Interviewer: Right.

Participant: (RESPONSE REMOVED TO ENSURE PARTICIPANTS CONFIDENTIALITY)

Interviewer: Right.

Participant: (RESPONSE REMOVED TO ENSURE PARTICIPANTS CONFIDENTIALITY)

Interviewer: Right. No.

Participant: What I can do is talk about the issues that I've seen because of it. You see where I'm coming from?

Interviewer: Yeah. So, I guess what I want to know from you is the overall drug problem, how the drug problem got started and the use of Opana within the community. So, if you could talk about all that.

Participant: The – actually the drug problem started with the Opana and what happened is we cut the supply of dope off. The police cut the meth off, cut everything off on the dope and what happened was that people were getting pills, they were going to the doctor and they were getting pills. So that supply of dope was never cut off because there was endless supply of doctors that were willing to give people the pain medication. So they went to Opana. And to get the effect of Opana, because they started out with OxyContin years ago and OxyContin created a film where if you manipulated it that it couldn't be – you know what I'm saying, it lost its effect. Well, Opana came out on the market and Opana was about twice as strong as what an OxyContin was so they started shooting up these Opana the same way they were shooting up the OxyContin. That's one reason why whenever that first started going on, we had all the deaths, all the overdose deaths. So, once people realized that the Opana was doing that, of course, they changed a little bit. And the problem of it is, and where it really got mixed up, is they were using dirty needles when they were passing out the needles. What we have seen in the policy agency, the reason why it got spread is because most of the people were street addicts. They didn't have any money, they didn't have jobs, they didn't have money. And all they were able to afford – three or four of them would go together and buy a quarter of a pill or a half a pill. And then whenever they mixed that up, they all had to use the same needle because there was no way of them sorting out – when they were freebasing it, there was no way for them to get their share. So what they'd do is they would all go together, that's why they were sharing the needles and that's how it got started. That's the main reason how it got started. Now, obviously, you know what I'm saying, they're handing out a bunch of needles. So here's the thing about it; on the law enforcement perspective, it's a nightmare for us because we have all these needles that are floating around here. But you know, obviously on a health perspective they're saying it's effective. So we've got to go with health over law enforcement. What we're seeing now is that the people, the addicts, are so irresponsible that they're throwing these needles out, even the needles that are given. Instead of exchanging them, they're just throwing them away. They're throwing them out there everywhere. And we're not only seeing that here, but we're also seeing that in other places where they've got needle exchanges that have started.

Interviewer: So not just Opana, but when do you think the drug problem within Austin really started?

Participant: With the shooting up?

Interviewer: Yes.

Participant: It started up about 2013, whenever they changed the Opana where you couldn't manipulate them – or I'm sorry, the OxyContin, when they changed them. When the Opana came in that's when everybody really started shooting up. And also what transpired was that because the Opana, whenever everybody found out what was causing the deaths and then when the police started hitting the doctors and the Opana and the supply of Opana dried up, they stopped prescribing them, the doctors did. So they switched over to heroin because heroin has the same effect as what Opana does. And the heroin, after that came through, the heroin is really what started it, the drug problem and the needle use. Because with heroin you have to shoot it up. That's the easiest way, to shoot it up. The easiest way is to shoot it up (inaudible). So that's when we really started seeing the surge in the HIV and the disease spreading. What a lot of people don't understand is that before we had the HIV epidemic, we had a hepatitis C epidemic which was being spread. And then, whenever the HIV hit, it was just an expansion of what we already had with hepatitis C. And the reason why it continues to be a problem now is because everybody is using heroin because they can buy heroin cheaper now than what they can buy Opana. I could really fill it in if I could talk about what caused it because there's a lot of stuff that caused it, some that I can't talk about.

Interviewer: Right. That makes sense. So, how do you think the problem has grown?

Participant: Right now it's kind of leveled off. We don't feel like it's grown much. As a matter of fact, in the last five months, we've been hammering everybody, made numerous, numerous arrests. We went after the major players in the drug business. We've got a lot of those guys locked up. So with that, we've felt like there's a little bit of a slowdown, and we know there's a slowdown because we're getting reports from the street that they're having a lot of people sick from not being able to get the pills and not being able to get the drug. But it's just a matter of time before they find another supplier, because if somebody is hooked and they don't get help to get off of it, they're going to find a way to (inaudible). They're going to do something.

Interviewer: How do you think this drug problem reached this level within such a small rural area?

Participant: Well, the issue of it is this: It's everywhere. This problem is not just designated here. The issue came about whenever the HIV started. And because it is such a small area and because everybody knows everybody, it was just like a cold in a classroom, like a kid gets a cold and before it's done the whole classroom gets it. All these addicts are together, they're running together, they're staying together, so it was just like passing the flu. That's how it got started and spread so quickly, because they were all sharing everything that they had.

Interviewer: What are the city and county police doing to stop the problem?

Participant: Hammering everybody. Zero tolerance on any type of drug. We're going after the dealers, we're going after the users, we're going after everybody. We're not just targeting large dealers; we're targeting everybody that's got anything to do at all. And that's including the doctors, the major dealers, everybody from the top to the bottom.

Interviewer: So, are the State police doing the same thing?

Participant: Yeah, we're all working together on it. We're actually taking the lead because we've got the resources to do it. We've got the money and the officers and the detectives and everything to be able to do it. And we're working with Austin on a daily basis.

Interviewer: So essentially what this study is going to be about, we're going to look at like the police department, maybe the pharmacies here, the school and maybe a couple of others to see what they did in relation to ...

Participant: The result of it.

Interviewer: And then...

Participant: The issue of it is, too, is we're not seeing a lot of doctors here – like there was hardly nobody here prescribing Opana once the epidemic started. The problem we had was people that were bringing them in illegally or people that would travel all the way to Chicago, Cincinnati or wherever to a doctor that would prescribe them Opana pills.

Interviewer: Anything else?

Participant: Yeah, actually there is. At first, when this thing first started several years ago is when unemployment was up pretty good, and we felt like the reason why there were so many people that were doing it was because they just had a feeling of hopelessness, they didn't care. They didn't have a job, they couldn't get a job, they had nothing, they were living on the streets and they didn't give a care whether they lived or died. But now as this thing has progressed, the jobless – unemployment has gone way down. We've got factories that are actually hiring felons, hiring people that are addicts just because they need workers, and it's not helped any. We've still got our same addicts. And another problem we've seen from a law enforcement perspective is that rehab centers, they've destroyed the credibility of rehabs in the eyes of the police. And the reason why is because they used rehab as a way of getting out of trouble instead of a way of getting cured. So the first thing that happened when somebody got arrested, they'd say, "Well, I'll go to rehab." They had no intentions of getting cleaned up; they just knew if they went to rehab they wouldn't get charged through the court with a crime or

the crime sentence would get shortened because they said they would go to rehab. And they had no intentions. As soon as they got out they went right back to doing what they were doing before. And what we've seen is there are rare cases of people who have gotten cleaned up. There are some rare cases. But to be honest, the vast majority of these people that we see out here on the streets that are addicts, the vast majority of them continue to be addicts until they end up overdosing or something happens to them. And we deal with them, the police deal with them on an everyday basis. We're the ones that are having to run them out of the abandoned homes. We're the ones that are having to deal with them when they're laying in the ditches passed out. We're the ones that are having to pick up the needles. We're the ones that are arresting the drug dealers. We're having to deal with this on an everyday – and it consumes 99.999% of our time as a police department. Everything we do revolves around the sale or all the crimes. 99% of the crimes that we deal with revolve around the sale, the using or the problem with drugs. It got so bad several years ago with people saying that – they would go get a prescription for their pain pills and then about two days later they'd call the police and say somebody stole the prescription. It got so bad that we don't do police reports for stolen prescriptions anymore. The only way they can get a prescription when they call us is we just tell them – we refer them back to the doctor. We won't do a police report for them. Because what they were doing is they were abusing the pills or they were selling them and they'd get a police report and they'd take it to the doctor and the doctor would give them another prescription. They'd get another 90 or 180 or whatever it was and then just keep doing that. So we don't do police reports for stolen prescriptions anymore.

Interviewer: What else?

Participant: The most effective means that we have seen to people to get them cleaned up is by maximum jail time because in the jails they can't get the drug. They get off of it. And then when they get sobered up finally in the jail and they get over their sicknesses then they start thinking again. They start thinking with a clear head and then they realize what they're doing is messed up. Let me see what else is there. One thing probably that wouldn't have there is this: We got focused because we're a small community, but we know as being a state police agency, we know that this problem is greater – it's the same or even greater in other areas. It's just that there's no way to really record the information of who's an addict and who's not an addict and who got arrested -- we have drug offenses that people get arrested for, but there's no way of tracking somebody that's addicted to OxyContin or addicted to Opana because they just don't come and turn themselves in and say, "I'm addicted to this drug." The vast majority of them will tell you that they're not addicted and that they just do it for recreation, until they get in trouble and then they want to tell you that they've got a disease because they think if they go to rehab – if they tell you that then they're going to cut the jail time. It's all a big circle. And the only thing we've seen to cure these people is jail time. That's it. We've seen the ones that have been sent off for years and they come back and a lot of times that's the ones that succeed. Unless they're gone for a minimum of one year, I mean gone. You see what I'm saying?

Interviewer: Go to prison.

Participant: Yeah. It seems like they're success rate is just zero almost.

Interviewer: So just for one year?

Participant: It has to be a minimum of one year. If they get sent off—

Interviewer: To have any type of success.

Participant: What's that?

Interviewer: So, a minimum of one year to have any type of success.

Participant: Any type of success in getting off of it, to quit being an addict. It does take that much time. And that's the minimum. Some people it takes two and three years. It just depends on how big of an addict and how long they've been an addict.

Interviewer: Okay, that makes sense.

Participant: And also what we're seeing is we're seeing – because of this, we're seeing a generation of kids that don't have any parents. We're seeing a generation of kids, seventh and eighth graders that are having to raise their four and five-year-old brothers and sisters because they're mom and dad are all geeked out if they're even in the home. They're all geeked out. So it's affecting everybody from the top to the bottom. And these people, when they get hooked on this, when they turn into addicts for the pain pills and the heroin, it's unlike any other addiction. They'll sell their great-grandmother's ring that's been in the family for a hundred years. They'll steal from their family. They'll steal from anybody to get their high, it don't matter. They'll sell anything they've got; it don't matter if it belongs to the kids or who it belongs to, they'll sell whatever it is or steal whatever it is to their high. That's different than any of the other drugs we've ever had before. We've been living it. We've been living it for several years. It started out – until the HIV came in, it was a massive problem we had with hepatitis C. We were fighting the hepatitis C battle. But hepatitis C at the time, nobody was worried about it until all of a sudden it turned into HIV. But the thing that aggravates us the most as police officers is you can go down to Jeffersonville and they've got some shelters and stuff down there, and there are people lined up around the corners and stuff, hundreds and hundreds of them. We've got 175 people here that are causing 99% of our problems. They've got thousands of them down there. See where I'm coming from?

Interviewer: Yeah.

Participant: And also, off the record, what hurt us was our stupid health department.

Interviewer: I know.

Participant: They destroyed us. They came out and stated we had 175 people instead of saying we had an increase, you know, this percent increase. The other counties were smart. Like Clark County, nobody knows how many they've got because they just said they've got a certain increase and they're concerned about that. See, no, our genius people came out and said they've got 175 cases. Idiots, man. Just plum idiots.

Interviewer: Well, and that's one of the other organizations I'll be looking at, is the Health Department, compare the State and the County, see what they've done that have had negative effects instead of a positive effect. (RESPONSE REMOVED TO ENSURE PARTICIPANTS CONFIDENTIALITY)

Participant: (RESPONSE REMOVED TO ENSURE PARTICIPANTS CONFIDENTIALITY)

Interviewer: (RESPONSE REMOVED TO ENSURE PARTICIPANTS CONFIDENTIALITY) But she just helped with a study and found out about how the drug culture is changing here, how it's shifting, the people using. Because they found people using drugs together, like any cohorts, and so now it's – they found like people are bringing their own needle now to these parties essentially, like these drug cohorts.

Participant: Well, the problem with that is we're still seeing the same problem. They can't afford – we've got these street addicts, they haven't got any money. If one of them goes and steals something or comes up with \$25 or \$30, you know, they've got a quarter of a pill. So there are five of them there that's using this same pill so they're using the same needle. We're still seeing them use the same needle, no matter what. I mean, there are some of them that are using different needles, but the vast majority of them are still using the same needle. Because, like I said, how do you separate a quarter of pill that's crushed up and freebased, you know, when they put it to liquid form. You can't do it. So that's why they share it. They want every single drop of that liquid that's in that needle. So to get that, they're all using the same one. One of them will use it to 2 ml, the other one will use it to 4 ml, and the other one goes to 6 ml. And the thing about it is, too, is that we've had needles out here on the streets, there's never been a shortage of needles because they acted like people couldn't get needles, but they could because all they had to do was go to a farm store like Orscheln, TSC, they've got needles everywhere for animals and it's the same needles essentially as what humans use. So those needles have always been there.

Interviewer: That makes sense, too.

Participant: And the reason why we've seen people shooting up, there's two reasons; one of them is because the immediate high that they got from it. And secondly, it was an

easy way to share the drugs that they had. You can look at the 175 to 180 people that's got HIV in this community, and every one of them will be homeless. They're nomads. They're just running from here to there. Every one of them. I couldn't tell you, probably if somebody just happened to get the disease that was a guy that was cheating on his old lady or whatever it was, or picked up a whore that had it, that's how the other people are getting it. The vast majority of the people that have it here are the ones that are living on the streets and they're the addicts.

Interviewer: Right. I've talked to quite a few people at school and they're like, "Oh, so are any of your family or friends affected by this?" I'm like, "No, I don't know honestly anyone because"...

Participant: They're street people. And a lot of them are people that are really originally not even from here, but they came here because of the cheap housing. That's something else you need to put in there, too.

Interviewer: Okay.

Participant: Because of the cheap run-down housing, addicts were able to here in groups and rent homes and stuff and live with a shelter over their heads. Now, what the city and everything is doing to try to eliminate that is they're going to start buying a lot of these houses and they're tearing down all the old abandoned homes those people were in.

Interviewer: Yeah, because I need to do also like a background essentially of Austin, just like what it's like to live here and why these people are coming here essentially.

Participant: They're coming here because of – and another reason they're coming here, too, is that we make it easy for people to live here. We've got so many programs, so many social programs. We've got clearing houses, we've got churches that hand out food, clothing and stuff on a daily basis, meals, and also the cheap housing where they come in and rent a place for \$75 a week. That's some of the reasons why they're here. And some of the people are homegrown. I mean, some people are from here.

Interviewer: I also need to do a background on Opana in general. Is there any more you can say just about the drug in general?

Participant: Opana is actually a fairly new drug. It came out and really got popular, and the only reason why it did get popular was because of the fact that the OxyContin was designed where they couldn't manipulate it anymore. And obviously – from the street what we know – what the people on the street and what the police know is it's a very powerful pain pill. What it is, is it gives people a feeling of euphoria, they don't care about anything. And that's the reason why we at first it was so popular because people were struggling out here to survive, without jobs and stuff. And then of course, after the crackdown came on the Opana, off the record here because these big drug

companies would sue you, but I would like to see why they designed Opana without the same type of coating they had. And the only thing that you can come up with, off the record, would be that they knew they were going to make a mint on it. They saw how much money Purdue Pharma was making with OxyContin and so they wanted to get into that market. So that's – if the real truth is known, that's probably what it is.

Unknown speaker: HIV people are up there.

Participant: Where at?

Unknown speaker: On (inaudible).

Participant: Oh, the one-stop shop?

Unknown speaker: The Health Department. (Inaudible) \$80 for everything in the living room, that's including the (inaudible).

Participant: It's got to go.

(Inaudible – background people talking)

Participant: But that would be an interesting question that you could pose to the drug company; if they would tell you how much money they made off of Opana and why they did not make it to where it could be manipulated.

Interviewer: To make money.

Participant: Yeah, that's it. That's the bottom line. They knew OxyContin was changing and they felt like – they probably thought that their company – and I don't even know who makes it – but they felt like, hey man, we're going to make a mint, OxyContin is done here, they can't manipulate that, we'll really do well. And another interesting thing would be to see – this was always a rumor but we never could confirm it because the doctors are tightlipped, but we always heard that doctors were prescribing OxyContin so often because they were getting a kickback from the pharmacies, that every prescription they wrote they'd give them \$5 or give them a vacation to the Bahamas. We never could prove that, but that would be something you could look into, too, and see if that was happening because you could find out through your research. Another thing, too, that we found out is that most of these addicts, if they're not addicted to OxyContin, if they're not addicted to Opana and they're not addicted to heroin, they'd be addicted to ice cream. They've got an addiction problem. And no matter what they do, they're going to get addicted to it.

Interviewer: They're just an addictive personality.

Participant: They're just an addictive personality. They've got issues.

Interviewer: So that probably goes into the mental health issues and not having those types of group support systems as well.

Participant: Yeah, absolutely.

Interviewer: Alright. Can you think of anything else?

Participant: The only thing would be, too, is that we've seen that the drug culture has changed over the years. It was like before, when people were addicted to this kind of stuff, they would be embarrassed and they would stay hidden, but now it's like they're just out in the open. And especially whenever the news cameras and stuff started coming in, it was almost like it was a badge of honor for them to be known as an addict of this stuff, because they were getting so much attention from the news crews and from the newspapers and all this crap. And that poses a problem, too, obviously because, again, they were proud of it.

Interviewer: Alright, well thank you.

Participant: Thank you. (Content removed to protect confidentiality)

(END OF INTERVIEW)

Interview 3

Interviewer: Are you okay with this being recorded?

Participant: Yes.

Interviewer: Okay. Alright. So, can you just talk to me a little bit about the HIV and AIDS epidemic here in Scott County?

Participant: Sure. Hmm, when did that start? Probably a year ago when they started testing patients and there was just a big outbreak. I knew it was related to the drug use and prostitution. But, like I say, we haven't actually really dealt with a lot of HIV patients, so I'm not really sure where they're getting the medicine because the medicine – the drug of choice was opium and we didn't even dispense it, so I'm not sure where it come from.

Interviewer: Okay. So, I guess, what is going on with the pharmacy in relation to the epidemic? Like, is there anything they've changed?

Participant: At first they were going to do the needle exchange through the pharmacies and then they decided to open up another place to be able to do that. But now there was a pharmacy that they were going to start to just dispense the HIV medicines. So we weren't even doing – we've only got like four or five patients that get medicine through us. So, I don't know – I'm assuming that they're going to that pharmacy. And that's their option. They started it over here, but I'm not sure if it's still going on. I'm not sure, because we, like I said, we only have like four or five patients that we dispense.

Interviewer: Okay. So, these patients, I guess their medication is essentially the HIV medication is what they're getting?

Participant: Um hmm. Yeah.

Interviewer: So, what is something that you thought that may have changed or would have changed for you and for the pharmacy in general with this epidemic?

Participant: Wow, let me think about that one. I'm not sure about that one.

Interviewer: That's okay, that's okay. Let's try this a different way. So, I mean, do you feel like anything has been different since this epidemic occurred?

Participant: Not really. Not for us.

Interviewer: Not for you?

Participant: No.

Interviewer: So, have you seen any changes, do you think, from your like maybe customers? Or do they – have they asked you questions about the epidemic or how the pharmacy will respond to it in any way?

Participant: Not that I'm aware of. I don't think so.

Interviewer: Okay. That's really okay.

Participant: I'm not sure. We haven't really had a whole lot of changes with patients because a lot of the patients that are HIV positive were already patients of ours. So questions that they had, I'm not sure they even really...

Interviewer: So you haven't gained any new patients with the epidemic?

Participant: No, not at all.

Interviewer: Okay.

Participant: Patients that we've already had.

Interviewer: Okay. And so, essentially I guess all these new patients are going this other pharmacy...

Participant: Either going to other pharmacies or hopefully their taking their medicine.

Interviewer: Yeah.

Participant: But you know, with the poverty level, they're all getting government assistance. It's essentially free. So I would hope that they would be taking it, but we've only got like four or five patients that we deal with and they do take their medicine.

Interviewer: That's great.

Participant: It's not really changed a whole lot for us.

Interviewer: Okay. So, this medication that they have to take – is it something that you keep in the pharmacy physically or do you have to...?

Participant: We do not keep it because of the cost. If they do need it, they usually let us know a couple of days before they're out of their medicine. It's very, very high in cost, so there's no way that we could keep it. And I'm not sure other pharmacies do except for the one that is set up for just HIV patients.

Interviewer: Okay, that makes sense. So, has the pharmacy taken any type of action on this epidemic or any kind of steps to, you know, maybe help people understand what's going on?

Participant: Well, our pharmacist will, I mean, he'll talk to the patients. I'm not sure what their questions have been. We just, you know, they come in with prescriptions for it and we just dispense it and we haven't really changed anything.

Interviewer: Okay. So, do you feel that the pharmacy has been facing any problems due this epidemic?

Participant: No. We do have – I don't think we've had any problems but we do have patients coming in asking for syringes to exchange and we have gained a lot more patients that have controlled prescriptions. That's probably 15% to 20% of our prescriptions a day. Yeah, that's about it.

Interviewer: So, would you say that you have people who you think that are frequent drug users come here to get different types of things?

Participant: Yes. We have frequent drug users here. But like I said, the drug of choice is something we do not dispense, so I'm not sure. What we dispense is Norco, Percocet, stuff like that.

Interviewer: Okay. So, you don't do Opana?

Participant: We do not do Opana.

Interviewer: Okay. So, what – or why don't you do Opana, I guess?

Participant: As soon as this outbreak started, they – that's probably a good change there – we did stop dispensing it, but we only had like two patients on it. We were just told not to dispense it anymore. I'm not sure...

Interviewer: Okay. And do you know who you were told that by?

Participant: Well, actually we weren't told; we were just going by what the other pharmacies were doing and a lot of them were stopping, they weren't dispensing it anymore, so we stopped. I don't really know if we were really told to.

Interviewer: But just kind of following...

Participant: It was a choice, yeah, we just kind of followed what everybody else did.

Interviewer: Okay. So, are you talking about just the pharmacies here in Scott County?

Participant: That's, yeah, that's who we followed, like Walmart and I think Stewart's down here stopped selling it and CVS. So I'm not sure where people were going, but I think most of the pharmacies in Scott County stopped.

Interviewer: Okay. And then do you know about surrounding areas, maybe Seymour or Clarksville or something – did they do that as well?

Participant: I think a lot of them did, but I don't know for a fact. There's probably a couple in Seymour that we've talked to that they've stopped also. I'm not sure about Clarksville.

Interviewer: Okay. So, from this outbreak, do you think this has affected the pharmacy in any way, like in a negative way, you know, has it created any bad business or...?

Participant: No, I don't think so. No, I don't think so at all. We haven't changed a whole lot from... No.

Interviewer: Okay. So, do you think there's something the pharmacy could do to help the community understand maybe what's going on or steps that they could take to maybe help this epidemic in some manner?

Participant: We probably could. I mean, we could – I mean I would – we could probably help host a night of, you know, maybe the pharmacist speaking about it. It probably could help.

Interviewer: Okay.

Participant: But I'm not sure where people are going for their, you know, answers.

Interviewer: Okay. So, do you know if like someone like the pharmacist here and at the other pharmacies – do they ever get together to collaborate or maybe talk about these different drugs, drug choices that people have made? Maybe they're figuring out that, you know, people using these different drugs who are – who may be using a different drug?

Participant: Right. I'm not sure that they've actually like gotten together – maybe just talking over the phone.

Interviewer: Okay, yeah, that's fine.

Participant: I'm not sure, yeah, hmm. I don't think I know.

Interviewer: Okay. So, I mean, you said that this epidemic really hasn't changed your pharmacy a lot and...

Participant: Right.

Interviewer: Okay. Do you think it's changed the business here in like general within Austin?

Participant: I mean, other than increasing the patients that get, you know, get prescriptions, I really don't think it's changed us in any way.

Interviewer: Okay.

Participant: We've had more outside people coming in asking questions more than anything, more than patients. Like the Health Department or the State, they would come and ask questions too, but the patients really haven't. More, people wanting to know.

Interviewer: And how many – how much has the State addressed you or... ?

Participant: They've come in probably two or three times. I'm not sure what they've done with other pharmacies, but they have – they've come in and talked to our pharmacist.

Interviewer: Okay. So, do you know what they want to know about or why they're here essentially?

Participant: They're basically just wanting to know how many patients we have. They talk about the drugs of choice. But, other than that, they're just want to know how many patients we have.

Interviewer: Okay, that makes sense. So, I don't know if I've asked this question or not yet, but do you think that there's something that the pharmacy could do other than maybe talk to people, just anything else? Do you think there's something they could do that you would like to see happen?

Participant: I don't know. Maybe address the drug use, but I think that all starts with the doctors. You know, you have all these doctors writing it. I'm not sure that's really – it starts out with the doctor and, you know, they fill the prescriptions and the doctors just keep writing it. That's probably who it needs to start with, the doctors.

Interviewer: If you have a patient that you feel like is abusing drugs, what steps do you take to fix the problem?

Participant: We just make sure that they don't get their prescriptions more than two or three days before they're due. Because if you start getting them early, that means they're taking more than they should. But that's basically all we can do, is just make sure that they're not getting them early. But now the doctors are writing dates on them when they can be filled, so that's helping. That's changed.

Interviewer: Yeah, that does help. Well, can you think of anything else that you'd like to add?

Participant: No.

Interviewer: That's okay. Let's see. So I guess the patients that you do have, or that you started out with since you said you haven't added any new ones, have they had more questions now maybe about different types of HIV or medications? Or do they feel like there's only this one way or...

Participant: I think they just feel like they have one way. I mean, there's different sets of drugs that they put on each patient, but we haven't had any changes in them so I'm assuming they're working. We've only got four or five patients that get HIV medication through us.

Interviewer: Why would they want to come to this pharmacy instead of...

Participant: Going to the other?

Interviewer: Yes.

Participant: Most of – probably 75% of our HIV patients already came here anyway. The only problem is we do have to order the medicine. It comes in the next day. But I think they just like the small independent pharmacy. I'm not sure like the Walmarts and CVSs can treat them the same way.

Interviewer: Okay. So you guys kind of give them the one-on-one time, more personal.

Participant: Right. We don't treat them any differently.

Interviewer: Cool, very cool. Do you think that now maybe from all this media attention, has it helped the pharmacy's business grow? Or has it kind of shied people away?

Participant: It's probably more shied them away, actually, I would think because sometimes we'll have the medias set up in our parking lot.

Interviewer: Oh, that's very nice of them.

Participant: Yeah. So that probably sends people away.

Interviewer: Yeah, that probably does.

Participant: We've had that done a couple of times.

Interviewer: When something like that happens, you would think that patients with HIV or AIDS, whatever it might be, probably wouldn't feel comfortable walking in to get their medications or ...

Participant: Right.

Interviewer: So is there anything you guys can ever do about whenever the media is here?

Participant: We try to just send them on their way, honestly. We don't need any more publicity here. We usually just say, sorry, no, you can't set up here.

Interviewer: That works. Anything else you want to add?

Participant: Not really.

Interviewer: Alright. Great. I'm going to stop this.

(END INTERVIEW)

Interview 4

Interviewer: This is interview number three. So, are you okay with this being recorded?

Participant: Yes, I'm fine with it being recorded.

Interviewer: Okay. So can you just talk to me about the HIV and AIDS epidemic here in Scott County?

Participant: Well, the HIV and AIDS epidemic is basically a spin-off from the drug problems that we've had in Scott County for several years. Good thing and the bad thing about HIV, it's brought a lot of attention to our community now, so we have a lot more police and we have some programs set up to try to help some of our kids and the kids' parents.

Interviewer: Okay. So, what is going on with the school in relation to the HIV and AIDS?

Participant: The good – we had a great program come in from the State. The State of Indiana brought down some experts in the field and they put on a presentation for our whole school, staff, and our student body on one presentation. Then the other thing that they've done, they have come in and helped us with our health curriculum. They have come in and made presentations throughout the year – last year and this year. So we feel like, you know, our kids are better educated right now on the problems with that.

Interviewer: Okay. So, that's, I guess, what the State has done essentially for...

Participant: That has been a really good thing, yes.

Interviewer: Okay. So, what has the school done, I guess, in regards to the community or even to kids in general?

Participant: The school, you know, it's like any school, you just open yourself up and you take all the expert advice that you can get. You bring in speakers; you bring in things to make them aware of the problem. Our problem here with kids is how do you help them better understand, and for us to better understand the problems that they've had, because a lot of our kids now are not living with a mom and dad; they're living with a grandparent or they're living with a single parent. Quite a few of them have somebody in jail in their immediate family. So, you know, you have a lot of issues with that. So, the school staff being familiar with what's going on here has helped them help our students.

Interviewer: Okay. So, what is something that you think the school could do differently to improve what's going on or... ?

Participant: Solving a drug problem is very difficult to do, but I think, you know, really our beliefs in our court systems have been very aggressive with this issue in the last year. What can the school do? I think, you know, if we can furnish better healthcare for our own students, I think that would be huge. We're working on a grant now to try to bring some more programs in. You know, you have that dental program that comes in once in a while for our kids because our kids can't – they don't have the transportation or the parents to get them to some of these places. They have trouble getting just a physical so they can participate in some extracurricular activities. So, if we can do some of that thing and bring in the healthcare, that would be huge.

Interviewer: Okay, yeah, that sounds great. So what other problems do you think the school is facing in relation to this epidemic?

Participant: Well, the school in general here – lack of housing and that goes right back with your drug problem too where most people rent, they destroy a place, they get up and move someplace else. So, you know, your housing market doesn't lead (?) for communities to get young kids who want to come in and settle in the area. And it leaves them – they're restricted on where they can move to because in our town now, you know, you only have certain sections that, you know, that everybody owns a home. And a lot of times, you know, you walk down the block and it's all rental. The town, I think, is 60% to 70% rental right now, so that causes a problem for young people, like yourself, to come back and say, hey, I think I want to live here, but I've to find a house. I don't want to be in a house beside people who are doing drugs.

Interviewer: Right. Okay. So, considering the epidemic, how has this affected the school, or the students?

Participant: You know, the school has always been a safe haven. It's not changed that. So the kids, they want to come for the structure. They want to come and do that. And most of them do very well with that, even when they're going through terrible times at home. Likewise though, we'll still lose students. We'll lose students, you know, that people are moving because they don't have a choice. They can't pay the rent, they're moving in with somebody else. That's the difficult part.

Interviewer: Okay. So, how do you think this may have affected students in relation to other schools – so maybe, you know, traveling to other schools, just understanding that stigma – or maybe schools coming here?

Participant: Other schools will never understand. You know they can't walk in – unless they walk in your shoes, they're not going to understand. Even the people from the State that come in, they have a lot of great ideas but sometimes, you know, they're just great ideas because, you know, it sounds good, but sometimes it just won't work because of who we're dealing with. And then you get into our area too with the lack of education that is – goes along with the drug and the high dropout and the high school diploma rate.

Interviewer: Okay. So, before this epidemic occurred, what steps was the school – in regards to curriculum – taking for students to understand HIV, AIDS or these other types of diseases?

Participant: I would say our situation was like most places. You just go through your curriculum and you talk about it and it's a problem that somebody else is always going to have; it's never going to affect you or your family. And if it does affect you or your family most of the people say, you don't say anything. So, it's hard to get help you don't say anything.

Interviewer: True. Okay. So, what is something you think that the school could be doing that they're not doing or even teachers what they could do maybe to help the students?

Participant: We really need to try to have forums on the public because they're the ones, you know – your dropout rate, your higher – your kids who are 18, 19, 20, 22 years old with one child or one baby, just making ends meet – but those kids need help on how to go ahead and get a GED, how to get some training so they can make a productive life and not be living on Welfare and on how many number of kids you have so you can draw more money.

Interviewer: Okay. So, I've seen where kids in the high school – I don't know if you're aware – but you know, like they put out the news about a special information to the students, you know, was that seen around the school? Do you think that was helpful?

Participant: To an extent. You're also talking about, you know, with our elementary kids for example, sometimes it's over their head, over most of their heads. Even our sixth graders, some of those over their head. Our seventh and eighth graders, yeah, they can comprehend that. But a lot of times – and then, it's the same thing with the kid who gets on drugs – I'm never going to have a habit, I can do this, I can get off of it, but I'll never have a habit. And then all of a sudden they have a habit.

Interviewer: Okay. So, how do you think the media coming to the school so much – has that affected the kids and school system in general?

Participant: Nobody wants to know – or other people to know – that we haven't done well in the community. So, you know, if we do something at home, we don't want our parents to find out. If we do something as a community, we don't want people to find out about it. If we have something with basketball – for example, that Louisville Cardinal deal where they have all that going on with them – they didn't want anybody to find out about it for a long time. And then after you find out about it, you start correcting the problem. And that's what we have to do. But the news media, you know, they come in and they'll interview some of the people that will talk to them and they'll choose sometimes people who make it really as bad as it can be. And I'm sure there's several cases that it's horrible, but for a lot of people. It's not – it's different sections that you get into, with like any family or any town, you have that.

Interviewer: Okay. So, have the teachers experienced or come to you about any issues they've had maybe following this epidemic, you know, in relation to how their students are acting or maybe they found that their parents now have this or a friend?

Participant: Well, we have some, you know, it's like I said – most people, if you have HIV, you're really not going to publicize it and wear a sign that says: oh, I'm one of those kids with - my mom and dad have HIV. They're not going to tell that. Now, they may tell that to certain teachers they have full confidence in and or a counselor who will not be talking to other people about that, and they do relay that and they talk about their family. But usually it takes a special relationship for that to happen.

Interviewer: Okay. Is there anything specific that the counselors have had to do in relation to this?

Participant: Counselors, you know, we had the State come in and we had them talk to them. We had the hospital – they have some people there or have organizations and we try to belong to some of those. So, they get as much background information as they can so they can help our kids.

Interviewer: Okay. Is there anything else that you want to add? Anything else you want to add to this?

Participant: No.

Interviewer: No?

Participant: I'm good.

Interviewer: You're good? Alright. Thank you.

(END OF INTERVIEW)

Interview 5

Interviewer: This is interview four and would it be okay if I record this?

Participant & Participant: Yes.

Interviewer: So, can you just talk to me a little bit about the HIV and AIDS epidemic here in Austin?

Participant: Do you want to start off?

Participant: Well, it just – it sort of hit suddenly before we even realized what was happening and kind of the way we were ushered into it in our church was we had some people who were recovering addicts that had really just come out of addiction, and when they heard of what was going on, they found that they had friends that were going and getting tested that they had been spending time with that were HIV positive and so they were very concerned. And at that time, it was the very beginning of the epidemic and there was no place to be tested really except for like the drugstores and things. We went to Seymour to I think Walgreens or CVS, one of those, and we had to just wait and then people would come out and they would either look relieved or they would be, you know, crying. There was not much privacy. It was just a really – it was a hard time when they came out and he actually did have it and she didn't and they were married and they couldn't really understand what was going on, but it was just a really tough time. They didn't even know what that meant for them, you know, because, you know you hear such horror stories and for the longest time, you know, HIV was a death sentence, and you know, we really weren't sure. And so that's kind of how we entered into the...

Participant: They had no transportation to get up there and they asked if we could find a way for them to go up.

Interviewer: Okay. So can you talk a little bit about the church that you're with and, you know, what they've done to help with this issue and kind of what steps they're taking?

Participant: We're – we're like – Hope to Others is the name of it and it's something that we kind of put together about five – six years ago and it was a kids' club type of ministry to where we were working with kids on the street and families. And we were doing just a vacation bible school style type of thing and it kind of grew into a mission for adults too and people were starting to bring – well, some of the family members were starting to come. People – we were feeding people too – so people were coming off the street and people were struggling with addiction and so we were able to make friends with them. And as they were coming in, some people have gotten off the drugs and others are still on, but it's kind of like – it's been – it's been kind of like a, I don't know, just something different where people are able – comfortable coming in versus going through a traditional church. And we turned it into a church last year in order to just -- so we can write receipts and just be more supportive to the people who are contributing. And there have always been other churches that's been helping us with this mission – and, different denominations. First Christian Church, Grace Covenant Church and just people who knew us and our family and friends – they kind of – they knew what we were wanting to do, what our vision and our goal is. And so coming together it's just been like – it's like a community effort.

Participant: Because we're like in the right place. I mean, we're right kind of in the middle of it. We always have been. Wherever we've been, it's always been in the worst/best neighborhood for us to be in.

Participant: Yeah.

Participant: And so people will donate food, they'll let us use their busses to transport kids. They'll, you know, donate money to help feed people. I mean people are just – the other churches and just people in general – we've never ever asked for anything, but they'll just – people just come and give us things that we need, which is awesome.

Participant: And it's kind of – there's always been a trust thing too, because before we turned it into a church, someone would say, well who do I make the check out to? It's like, oh you can just make it out to our names. We had a separate account back then to put it all in, but we just needed to make it a real official thing, because the people who were coming, they called it their own church. And so now we had to kind of make it our own church but we didn't want another church in Austin, we had plenty of churches in Austin. And we walked into, I don't know what you call – fortunately into where we're out now because with the Community Church of God, with them closing that, there was going to be no way for us to afford paying rent and utilities on a pretty big place because we were used to a budget of \$200 a month and that was paying for just to help them with utilities over on the North Street place my friend, Brent Calloway had. And so we went

from that into -- just different people that were part of our church said hey, I think I can give a little bit more if we were able to do this. And kind of everybody coming together, and some of our family and friends, and so it was like, okay, let's try it out. And even with what we're doing now, other places -- other organizations are coming and doing different things to help them with different recovery programs and they're donating toward our utilities too.

Interviewer: Okay.

Participant: And so it's kind of like it's paying the bills and...

Participant: It's strange that we moved into that building right -- was it right before the epidemic hit?

Participant: It was just like right before it became news.

Interviewer: Okay.

Participant: Before it all the new stuff...

Interviewer: The media happened...

Participant: Yeah, the media...

Participant: Before then we were...

Participant: We saw it in the paper.

Participant: Yeah, we were in like a little school house, like Little House on the Prairie church. I mean we had little old pews and a stage and that was it, and a bathroom in the back. You know what I mean?

Interviewer: Right.

Participant: It was just very small. And it was just strange how it all worked. We got this building with lots of classrooms and a gym, and essentially all these different rooms and so all of these people would come to us and say -- CenterStone came to us -- which is a -- they do...

Participant: It's a community mental health place.

Interviewer: Oh, okay.

Participant: Like a LifeSpring, but they're in the next region over.

Participant: They wanted to use the building for a recovery engagement center. So, basically just getting people off the streets and giving them a safe place to go and then offering them – if they want help, kind of meeting them where they are with whatever help they're needing. Rather than saying, well, you come here and you do this; it's more like, well, what are you wanting to work on? And just trying to help them where they are. And that's on Monday and Wednesday nights and we have volunteers in the church who are recovering addicts who actually run that. And then Tuesday nights we have...

Participant: The women's recovery which is like a sex worker type of thing and it's run out of Indianapolis, Dr. Janet Arno, and eventually it turned into like any type of...

Participant: Women in poverty...

Participant: Women in poverty...

Participant: Sex workers. Anyone who is affected by addiction and stuff and that pretty much is everyone in Austin. I mean, so it's very open to all women and they just offer a lot of services for women. They're wanting to have some makeover and things to just kind of give them something to make them feel, you know, good about themselves.

Participant: And Dr. Arno, the main reason for that grant – it's similar to – there's one up in Indianapolis that I think is an Episcopalian church that they do something similar with the sex worker project – hopefully find them a different occupation and so that's what the – they want to engage the people and then hopefully point them in the direction – help them with protection and even physical and the other protection too, but even having groups, talking about the johns to stay away from, and things like that. And so they recently hired a social worker that's going to be a part-time social worker that's going to help run those groups.

Interviewer: Okay.

Participant: So, it's going to be Tuesday nights.

Participant: And then there's Hope Over Dope that comes in...

Participant: On Friday nights...

Participant: On Friday nights and then there's recovery meetings that meet kind of in conjunction with the recovery engagement center. Like on Monday night it's our own recovery group from our church and then on Wednesday nights it's AA.

Participant: The Hope Over Dope is like a – it's from the Peers Projects that's out of Indianapolis too. And, so like a lot of the people from Indianapolis have come down to

offer their services and help. And their hope is to use those peers in order to run groups. Let's see. And then on Thursday nights, we have our own service for the youth group. Before it was like a youth group and it's kind of their bringing their friends and some of the families are coming too. So it's just as big as our Sundays now. We have about 65 that are coming, and it's a mad house sometimes. But they come hungry – some of them – and so we normally just do sandwiches, bologna or whatever, or other donations from like Food 4R Souls, they do a food on Thursday nights too. Sometimes they'll bring us their leftovers and we'll either serve it then or serve it on the other nights. Becky and Paul Thomas, they're kind of in charge of the Food 4R Souls.

Interviewer: Okay. So, all these different things you guys are talking about, these are all held at your church, right?

Participant: Yeah.

Interviewer: That's pretty crazy. In Austin...

Participant: And this is like – people have come to us, hey, can we do this there? I was like, okay, well if we work around this, that and the other, it's fine. And then you throw in a baby shower and it's like, okay – the baby showers, we normally don't have anything on Saturdays, so (INAUDIBLE) baby showers, we can do that on Saturdays or Sunday afternoons. There's a lady on Sunday evenings that uses the sanctuary as a bible study and she preaches for some people on the street. There's only a handful of people that'll come – sometimes no one – but she and her husband, he'll bring his guitar and she'll play the piano and whoever shows up. We don't even go to that. We're just so tired and everything else...

Participant: We can't attend every night, I mean, so...

Interviewer: Oh, yeah.

Participant: But these people are all trustworthy and they have keys.

Interviewer: Good.

Participant: We've never had anything just – other than your cellphone, which we think it probably got thrown away – nothing's disappeared from the church.

Interviewer: Well good, that's pretty great. So, have you approached all these different programs, or have they been approaching you and the church?

Participant: They've all come to us.

Participant: Every one approached us. Yeah. We don't like to ask for help. We don't want to get kind of pushed in things – like we know that if God wants us to have it, He'll send it our way and we've always been that way. Even like when we started six years ago, it was like, when the funds dry up, we know our time is done, we did everything that we could. But so far, everything is like still working the way it's supposed to.

Interviewer: Very nice. So what has the church and the congregation done exactly to help with this epidemic? How have they been a part of it?

Participant: A lot of them are – they're actually the family members. And so we – our church has – we don't have any people that have true occupations possibly. Well maybe a couple that have real jobs, but most everybody they've been affected firsthand from their own family member.

Participant: Yeah, a lot of people have, yeah.

Participant: So they normally just spread the news about what's all going on at the church to try to get people to come in.

Participant: But the ones who are – who have been there, done that, like the past addicts, they have – they either help lead a, you know, like a recovery thing like the one we have on Monday night or another lady and her husband, they do a lot for the rec – they – she pretty much runs that and answers phones and makes people sandwiches, and so they definitely offer their time. I mean, she doesn't work anywhere, and so that's something that she can offer. So I think they do things like that. And the – the other people just are available for the kids because that's another part of it which people aren't really talking about it or seeing it, but it's like, we got there – you know, we got to where the adults were all sharing needles for a reason because that's how they grew up and that's how their people grew up before them, you know, whatever new drug. And then, you know, jail was just a normal thing. Everybody had gone to jail or was going to jail and you know that's our big thing – we want to break that cycle. We want the kids to know that, you know, they have hope. They have something they can, you know – they can achieve something – and not that their families are bad, but that they can even be an example to their families and help them.

Interviewer: Definitely. Yeah, I think that's a great point. So, with everything that's going on, do you think there's something that the church could do differently to help this or you wish there's something else that you could do?

Participant: We want a homeless shelter.

Participant: Or some type of transitional shelter type of place where a person can get on their feet and then they can move on. And we have so much couch surfing going on.

Participant: And so many calls where people will say, oh, is there anything in Scott County where, you know, a person can get a room for a night? And, it's like, unless a church has mercy and puts them in a hotel, they can't – and really that doesn't help that family very much because it's just one night. You know, they need – they need help. They need some people – like a support system to gather around them and not, you know, not just for one night but to really help them get the skills they need, help them find an outfit, help them get to the interview. You know, that's what they need and we don't have anything like that in Scott County or anywhere even really close by.

Participant: If you think about it, even like someone that would be a mentor, like would take in this family or couple for a certain amount of time and you're going to mentor them in your own home. That's kind of scary because you don't know what's going to happen. But that's what we really need, is someone – if we had a homeless shelter or transitional, we need mentors actually to be there all the time to run it. That's why we think about this couple that's – that's part of the rec and they've always – they could be mentor type of people, the house parents, and kind of like we're fostering our own adults and families.

Interviewer: Yeah, yes.

Participant: But, yeah, we would love something like that, but so far, I mean, that would have to be just given to us. We don't have the funds to go and, you know, to even get a place to have it. There's so many houses around Austin, it seems like that it would sort of fall into our laps, but as of yet it has not. So we figure it must not be God's plan quite yet. We must not be able to handle it yet.

Participant: Maybe that's someone else's gift that they will be able to do.

Participant: That's true, may be, but we just hope that that happens because there's such a need for that.

Interviewer: Is your church also involved in the walks that had been going on at first, that they were doing after the epidemic was found out, you know, they were going from house-to-house to pray with people and...?

Participant: They've used our church to do that and there are times that people from our church have been there. Like last week, they had it and I was there, they had it in our church and everything.

Participant: They're still having those.

Interviewer: Oh, they are still having those?

Participant: Yeah, they still do that every Monday and they're out walking again now.

Participant: We don't go to every one of them or anything.

Participant: No, we're so busy. But the good thing is everything is kind of running itself now so we don't have spread ourselves so thin.

Interviewer: Good.

Participant: But, yeah, they're still doing that. There's about maybe 10 to 15 people that are pretty consistent with that, and they've been doing that – they've been – during the wintertime, they've been meeting in different churches and praying there.

Participant: And then when it's nice, they'll walk around and pray on the streets, or pray with people if they want to pray, so...

Interviewer: Okay. So, from all this that we've been talking about, what are some of the problems that the community is facing, do you think?

Participant: I think a lot of what they're facing, I mean a little bit, is we kind of have the media preying on us and the people in the community. And if you're willing to talk, who cares whether you're giving any sort of – I don't know – something helpful or not, then they'll just put you on TV. Or if you're will to talk and your trying to actually say something coherent and intelligent and have some hope to it, then you probably won't get on or they're going to twist things around and take things out. We've actually had that happen and we don't even normally talk to the media anymore because, I mean, it's just like, let's just get this story. And you know, there is a story, but they're not telling it. And so, I think that's kind of a problem, everything is being sort of misrepresented and the stories of hope are not being told like they should be because, you know, they want the negative. But I think the main problem is just that people are trapped in addiction and people don't understand what that is. And, I mean, we don't understand firsthand, but from the people that we're close friends with now, what they've told us is that, you know, it seems like there's no way out. And even if, you know, there is help right there being offered, sometimes you still can't take it, and so, just – I don't know...

Participant: It's kind of like if you have someone there right now, it's like, I can take you right now over to the whatever facility and the person's like, I'm not ready to go. But later on down the road, they're like, okay, I'm ready to go. That person's not there. We can't find – I wish we had our own 9-1-1 system where you call this number and say: I need – I'm ready to go right now.

Participant: Because when they're ready, they need to go then because then once that – it's like it passes within that day and they're right back where they were. They have this moment of clarity and they need to go then and they might be able to make it. But if they just kind of go back to where they were, then they may never get out.

Participant: If there were like an ambulance or some type of system – you call that number and they send somebody right there – boom – they take you out then.

Interviewer: Yeah, that would make sense. So, what problems has the church faced from this epidemic? Anything?

Participant: I don't know that we've really faced any problems. We've always dealt with like seeing needles around and things, but not like on a huge basis. But I mean, sometimes, we do have to, you know, clean those up, things like that, but...

Participant: Fortunately, I mean we've been trying, with my Masters in Social Work and the stigma about the needles and all the other stuff, we've been using just education and telling them about the reason why – what health reasons why about the needles, but also there's that hope of seeking treatment and...

Participant: Well, and people are even, like a lot of people in our church were confused about how you even got HIV, especially older people, and they were, you know, they were really were unclear in their facts. And so, that was kind of a barrier because we were afraid that – are these people not going to be open to people with HIV coming into our church? Because we're open to it because we're aware of, you know, how things work, but they were worried about toilets and things like that, and so we had to really, you know, educate them on that and even tell them that we do clean things very thoroughly, but that's not going to happen and you don't need to worry about that because education is a big part of it. And you – you just don't – I don't know – if you're an older person and you don't go, you know, to certain things, you know, you just don't hear and you don't know the newest things and you just kind of get, I don't know, like a superstitious sort of, you know, mentality.

Interviewer: Yeah.

Participant: And we have a superstitious group anyway from our church. They grew up that way. They grew up...

Participant: It's like an Appalachian culture. It really is. When we first started working people from Austin, we were amazed, we felt like missionaries. It wasn't a different language, but it was definitely a culture barrier and we have lived in Scott County our entire lives and we didn't know that culture, and so we had to learn. And luckily we had, you know, a family...

Participant: This one lady – this family took us in like we were their own...

Participant: Yeah, and just told us – that's not how we do it, we do it like this. And we're like, oh man.

Participant: And it's like, so – without us putting ourselves out there, they kind of took care of us; no, you need to – don't say this because that person is going to get mad if you say this; you need to do it this way.

Interviewer: Wow.

Participant: Or, or whenever they would hear a rumor that – one time they thought I was an undercover DCS worker trying to build up a case against this grandma and I had to tell the grandma that is not true. Yes, I work for DCS, but if it were anything, I'd be building up a case for you because you are taking care of the whole community. And, it's like that honesty was always there and we were able to keep that.

Participant: That was a big thing, I think. And, I don't know if it's just this culture, or any culture, but if there was ever any hint of like if people are upset about something or there's a misunderstanding, we would just go to that person's house and we'd be like we don't want there to be a misunderstanding, you know, let's talk about it. You know, and I don't think that happens as often, but I mean, we just – we were like this is life and death, like these people, if they go out, you know, they – we are their last hope of church because, you know, other churches they don't feel comfortable going. So, we just wanted to make sure that we didn't mess it up. You know what I mean?

Interviewer: Yeah, yeah, yeah, it makes sense. So before this epidemic occurred, what was your church doing in regards to understanding HIV and AIDS or drug addiction here in Austin?

Participant: We knew that the drug addiction was here and we tried to do some recovery programs, kind of on and off on Saturdays and they didn't really take off too well.

Participant: Then we started on Tuesday nights – we started a recovery group.

Participant: Yeah, we had a recovery group going on Tuesday nights and that was kind of back and forth too – and because our goal was – one of our biggest supporters is Participant's father who's 20-some years of sobriety and really big into the AA Society of Louisville and so he, financially, he really supported us over the past six years.

Interviewer: Oh, wow.

Participant: And so our goal was to try to have something similar to AA or even AA right here in Austin because we didn't have that. And so we had different types of recovery groups going. He even came and helped lead some groups for a while on Saturdays when he'd come for a visit. It just somehow or another, people just didn't – people didn't want to go.

Participant: I think things just fell into place more when everybody – when people realized, I don't know, more that there was a need. I think then people came out of the woodwork to help, you know.

Interviewer: That makes sense. So, on to that – so what should – what is something that we should be doing here that is not happening? You know, what is something that your church could do, or even the community?

Participant: I don't know. There's still – addiction is still there and people are not going to recovery groups because they're still suffering with addiction and so they're not going to come. I don't know. They have to hit rock bottom on their own.

Participant: But I mean, they're doing so much; we have the needle exchange, we have, you know, lots of people – their helping people to get insurance. I think they've really tried to do a lot of different things. I really think the thing that's been overlooked is the children. I don't think – I think they're thinking now and they're not thinking future. And I really, I think they're missing it because it's much more difficult to deal with the problem now than it would be if you would have prevented the problem to begin with – or at least on some scale.

Participant: A youth center that's opened up...

Participant: Yes, a youth center would be...

Participant: Seven days a week, a place for the kids to go to so they don't have to see the things that they're seeing now. Manned by volunteers or some staff or whatever. But it really needs take place in order for – they can have other programs going on right in there. You know, churches could go in there and help volunteer for things and just mentoring.

Participant: Yeah, that's what they need, mentors, and they need something that they – you know, goals. They need something that they can look forward to, like, you know, if they had certain programs or even if they did little studies on, you know, different careers and things like that. That's just something that they don't have right now a lot of them.

Interviewer: Okay. Yeah, that's great. So is there anything else you want to add to this or that you can think of that might be helpful?

Participant: I don't think so. I probably talked your ear off already.

Interviewer: No, it's been great. So, if you think of anything else, just let me know, but I really appreciate your time.

Participant: Thank you.

Interviewer: Yeah, thank you.

Participant: I don't mind talking to you. You're not the press.

(END INTERVIEW)

Interview 6

Interviewer: This interview is my sixth interview, so are you okay with this being recorded?

Participant: Of course.

Interviewer: Okay. So, can you just tell me a little bit about the HIV and AIDS epidemic here in Scott County?

Participant: Gee, where do you start? One of the first things I tell people is that here at our Health Department, we never handled anything with HIV. There are only so many HIV Departments in the state and they handle multiple counties. So ours is in Clark County, which is the county just south to us. And, so they handle 16 different counties, which is kind of crazy to me now that they're so busy, and they have the HIV and STD testing there and then the people that have HIV, they have the Care Coordinators that help handle those people. So, they've always handled that. So, honestly, I didn't even know how many HIV cases we had in our county. I've been the Public Health Nurse here for almost eight years, and so since I never had to handle that, they always handled it, I never really knew how many we had. After the outbreak, you know, I realized we only had like three cases in five years, or something crazy, so it was really, really low. So I had to learn a lot about HIV really, really fast.

Interviewer: Yeah, that makes sense.

Participant: We kind of, we kind of got thrown into it, you know.

Interviewer: Yeah.

Participant: You learn a little bit about it in nursing school, but when you don't deal with it every single day, we all here at our Health Department basically we learned from scratch. We had to like learn really, really quickly. The outbreak, basically how it happened for me was in January, I got a call from the Indiana State Department of Health, from the HIV Division, and they said you know we're seeing an uptake of HIV

cases in your county, you know we're working on it; just wanted to let you know that, you know, this was happening and that we're taking care of it but we're going to see how it goes from here. And so we're like okay. So we were kind of a little bit worried and then it was a very long, couple weeks after that, they were like, okay we're going to start having meetings at Clark County. So we went down to those meetings and the State Department of Health was there and they had LifeSpring, which is the mental health services there, they had us and of course the STD Department and then their Health Department, their Health Officer was there and their administrator. Who else? I think that's pretty much it there in the beginning. So we all kind of started having meetings once a week to determine what going – you know, what was going on, what was happening. They have – they have so many different specialists, like there's a media person – you know what I mean, and there's a person that handles their surveillance part and there's a person that handles the lab part. And so they had all of those people in place, pretty much ready to go. And from what I understand, the first person they found was a pregnant woman that had gone to have her routine screening done, which you get tested for HIV when you're pregnant. So they had tested her. She was positive and the DIS worker, who's the disease intervention specialist, their job is to go to the person who is positive and do a contact tracing. So they basically ask them who your sexual partners are, if you do use needles, who your needle sharing partners are. So she said she had shared needles with people in her house. So the DIS worker went to that house. She ended up testing six people in that house that day, and they were all positive.

Interviewer: Wow.

Participant: So, she was like, I knew pretty quickly that we were in trouble. Like, you know, this is not going to be good. So after that, it really spread. I mean us finding the cases went quickly because those DIS workers are amazing at finding the contacts and then getting all of them tested and so that number just really went quickly. And I remember going to one of the meetings in Clark County and they – the state had a contact tracing form and it was like a big form and it had the ways people were connected.

Interviewer: Oh wow.

Participant: And so it had like the positives and then it had like if they were a sexual partner they were a red line and if they were IV drug user, you know, they shared needles, then it was a black line, and it was like a cluster of black.

Interviewer: Wow.

Participant: Like they were all – you know what I mean? They were all interconnected in one way or another and it was like shocking at that point. We were like, you know, we have a major problem. And we knew that we had an IV drug problem mainly from our Hep C. We've been battling the hepatitis C numbers for years. So we knew that – that we had this problem, but really like what do you do about it? Where do you go? You

know what I mean? What do you – how do you handle that? So we kind of got thrown into that quickly too, but. So, I mean, we realized pretty quickly that it was, you know, it was a needle sharing problem is what it was. CDC came in pretty quickly. They brought in all their experts and they were amazing – like some really amazing people came. And then they brought in lots and lots of DIS workers from all over the country came in to help. And so that's why like our numbers went up so quickly. Like, you know, you see them going up and they like shoot up – it's because all these DIS workers came in and they were finding people like crazy that needed to be tested, and so they pretty much found everybody they needed to test. We are still having what they call blitzes where they come in and they test all the people that they tested last year that were negative to make sure they're still negative so that we can keep up on that and make sure they're not converting or still doing bad things and getting...

Interviewer: Right. That makes sense. So, these meetings that you were having in Clark County, is that – who did that consist of? What were these meetings about?

Participant: Do I even remember? It was such – it was such chaos. They're about lots of different things. I mean, mainly like what is our problem and then where do we go from there. So like, you know, once you realize that it's an IV drug problem, you know, LifeSpring's there – the mental health services – okay what can you do to help us because we're going to have to, you know, do more to try to get more people in treatment. Everything happened really quickly. Of course, we had the media there, the media relations lady, and you know you have to get education out. People are – I mean they were freaking out. I mean, people didn't want to eat at restaurants and people – you know what I mean? Like there's so much stigma and so much education that - still, every day, we're doing education on that. It's like, well, you can't get HIV that way. So, I mean, it was chaotic there. And so we had the media relations lady that was helping us with all of that, trying to get the good news out, trying to get the education out to teach people, you know, it's okay, you can eat at the... What else? We were trying to figure out what we can do because Austin is only five miles from Scottsburg, but for people that have no money and no transportation, it might as well be in Louisville. You know what I mean? Like it might as well be a hundred miles away. It doesn't matter to them because they can't make it here. And so that was another thing that we were working on different ways we could get things in Austin to try to get help because there was only the one doctor there in Austin and that's basically all they had and so we were trying to figure out how we could get the people that are positive treatment and the people that wanted substance abuse treatment get them treatment for substance abuse and then get everybody tested that needed to be tested. And then the state came in and they brought all their preparedness up-staff and they basically – we basically opened up the one-stop shop in Austin. We have a factory – an old factory that was abandoned and we just took it over. So CDC was in there and ISDH, and of course, we were in there. We ended up – and what they kind of modeled it from was from the tornadoes went through several years ago. The state had done a one-stop shop down there because some people had lost absolutely everything and so they made this one-stop shop so people could go in and get

everything they needed in one place. And so we kind of did the same thing and it really was handy for people because they needed to sign up on insurance, and since they expanded the HIP 2.0 insurance, most of these people were eligible for the HIP 2.0 insurance. So we had navigators there who could sign them up on insurance, but they had to have a birth certificate and a driver's license. So Vital Records was there to give them a birth certificate, BMV was there to give them a driver's license. There were testers there, we had immunizations, people could get immunizations, because you've got to catch them when they're there for that. We were giving like hepatitis A and B shots, because if they had Hep C, it'll protect them from those. and then TDAP shots for the tetanus and pertussis, and then, what else did we have? Immunization. WorkOne was there to help people. Anybody that wanted to get a job or find a job, they came in and were helping. And then we ended up – of course LifeSpring was there so they could counsel people or try to get them into the inpatient. And LifeSpring actually, there for a while, gave us – gave Scott County residents priority because it was like an eight-week wait to get in.

Interviewer: Oh wow.

Participant: But they gave Scott County residents priority so it was more like a week or two there for a while and then it was four weeks, and now we're back to like six weeks or six to eight weeks before they can get in. It's the closest inpatient is Jeffersonville. But it's what we have at this point. So what else? That's when – then we started the needle exchange and it was all there in the one-stop shop too. So people could literally come in and get all this stuff done at once and they were pretty amazed. Like I don't know how many times people were – and they were like in shock – like I just got everything done I needed to get done. And I'm like, I know, that's the whole point! (LAUGHING) The whole point of the one-stop shop. And they're like – because normally, I mean, they'd have to go all over town to get all of this stuff done.

Interviewer: Which could take days.

Participant: Could take days, and you don't have transportation, you don't have any money, it's – it's too hard for them and they just give up and they don't do it so.

Interviewer: Okay. So, were you having meetings with officials here in Scott County as well?

Participant: Um hm, yes, they were on top – of course the Health Board met a lot back then. In the old days, I think they only met three, four times a year maybe, you know, like not very often and then they were meeting like three times a week. You know what I mean? Like we have to have another meeting, we have to have another meeting. So of course, the Health Board was always involved and then our commissioners got very involved and so they were coming to the meetings too, and so we had a lot of those

politicians that were involved too, and they have to be because they have to make the policies and things for our county.

Interviewer: So, with this issue, would you say that the Health Department kind of owned this issue and then, you know, kind of dispersed to other people, other organizations on what they can do to help fix this, or did you give any guidance at all?

Participant: I would say probably yes, the Health Department probably was lead on it just because it was a public health issue, you know what I mean? And that's what like even, you know, the Sheriff is like I doing – I'm going to arrest people, I'm going to do this, I'm going to do that, but this is a public health issue and so I'm going to let the - you know, the Health Department – the health officials handle it. And so I think since it was such a public health issue that we were forefront in that of course.

Interviewer: Yeah, so what other actions has the Health Department taken for this epidemic?

Participant: The IU docs came in, the Infectious Disease doctors came in to help and they were a tremendous asset. So we had them here for a while to treat – to get people on treatment, to start them on treatment. And we had a lot of people that started treatment, you know, are doing really well for the HIV. And then – so I'd say that's part of it. They actually left and they're getting ready to come back. It's been a whole contract issue, you know how all that stuff goes, that's way out of my league, but I'm like oh just sign it, somebody sign it. You know what I mean? So we're hoping to get them back the beginning of May. Someone said they're supposed to come back. So, it's been several months, we're like we need them back, we need them back, so they're supposed to come back and that's a tremendous asset. We've worked really closely with LifeSpring because that is still – still even a year later, something that we're really, really lacking in is substance abuse treatment options for people. You know, like I said, it's like eight weeks, six to eight week wait to get into Turning Point. We don't have any medication assisted therapy or MAT they call it. The only way that LifeSpring will write you MAT is if you go through the inpatient, which doesn't work for everybody, but LifeSpring's trying to get more doctors that can write for Suboxone. That's what most of our users want and they've found that it works the best for them. I mean, they – it's gotten so bad that they're buying it illegally on the street because they're trying to quit themselves. So, I'm like ahh! It's not good that you bought it illegally, but at least you're trying to quit. I mean, I don't know, you know what I mean? I'm like in the middle on that one.

Interviewer: Yeah, right.

Participant: So, but they say it works. So you know, if it's something that works, then we need to try to see what we can do to help them actually quit, you know. I had a girl that was talking to me and she is like, you know, I took a half a pill and she's like, I didn't need anything – I didn't need any drugs for two days. She's like, I felt really good.

I'm like, well that's fantastic, but let's try to get you a legal script for that and then you can stay on it and you will be doing well. We have a lot of – we have a lot still to go. But, of course, the needle exchange program was huge. It was the first one in Indiana because it was against the law before the needle exchange – before the outbreak – HIV outbreak. So the needle exchange was huge and the Health Department – I mean, we developed that from the start. Thank God with CDC's help and ISDH – they both helped tremendously in getting that started because it was one of those things where it was – it's illegal to do and you're not even allowed to talk about it, like, don't even bring that up. And then they were like okay, you can do a needle exchange, you've got 30 days and the clock starts now. And so we're like ahh! So we basically had to start from scratch but thank goodness there were some experts from CDC that basically walked us through that and helped us tremendously. So I would say that the Health Department, you know, that was a big thing. There is an FQHC in Austin now, right in downtown Austin. Yay! And a Federally Qualified Health Clinic, and that is tremendous. I mean, I wanted that since I started eight years ago.

Interviewer: Wow.

Participant: Because the closest FQHC is Seymour and it's a two-week wait for a routine appointment.

Interviewer: That's insane.

Participant: So people just wouldn't go, you know. And so if I referred them there, they just wouldn't go because it was very frustrating. So the fact that LifeSpring brought the FQHC in, that's huge; so that's going to help tremendously. I mean, there's been a lot of changes, like even little things, like transportation. There's Southern Indiana Transit System, I think. SITS, it's called. You know, we all sat down with them and we're like, what can we do to make transportation better? And so they made an actual route where they go through Austin and they all bring them to Scottsburg and back. And they actually have a route now so they have more transportation options. There's a lot going on in the jail. The Sheriff has done a tremendous job. He understands that the majority of his people have substance abuse problems or mental health issues, and so they've brought LifeSpring into the jail and they're doing actual meetings in the jail with the people and then they can help get them into, you know, inpatient if they want that. He's actually getting ready to start Vivitrol, which is a shot that they can get that will help prevent cravings.

Interviewer: Okay.

Participant: It's working really well for some people. Some people it doesn't work at all, but some people it works really well for, but they have to be completely withdrawn before they get Vivitrol. So that's why it's really hard for us to give that, because it's hard for someone to completely withdraw on their own, but if they're in jail, they're

already withdrawn. So that's why the Sheriff's like, well this is the most logical thing, is to wait until their completely withdrawn while they're in jail, then right before they get out we can give them that shot. And so that's something else that we're trying to – he's getting ready to start that and then LifeSpring and Dr. Cook's office in Austin can both give the Vivitrol afterwards, because it's a once-a-month shot. So after they get it in jail, then they have to come back a month later and get another one.

Interviewer: And how long is the series, as long as they want?

Participant: As long as they want, I think, and hopefully it's not too long. I mean, since it's so new, we only have a few people that are on it, and I haven't heard anything about long-term, but the few people I know that are on it are doing really well.

Interviewer: Good.

Participant: A guy was just in here the other day and I hadn't seen him in a while and he said, I don't come to needle exchange anymore because I don't need to. And I said, well are you, you know, are you – he said my wife and I are both doing great, he said I just got a new job and they were just getting ready to lose their kids. They had a DCS case. And he said we've got the kids, everything worked out with that. I'm like, great!

Interviewer: Yeah, that is good. So is the needle exchange still currently going on, right?

Participant: Yes.

Interviewer: Okay. And so you said at first it was only for a 30-day period and then they've extended it?

Participant: Yeah, it was a 30-day period and then they extended it another 30 days, and then it was a year. And so our year is actually up May 25th and we're actually in the renewal process now. The State just gave us guidance on that last week and we have everything in place, we just have to go to the Commissioners' Meeting this coming week and then have them sign off on it and once we do that, then we send it to the State and we're done. So, and it's only yearly, so it'll be just for another year until next May 25th and then we'll reassess if we need it again.

Interviewer: So, actually back to the meetings that we were talking about, the ones that you were having with the officials here in Scott County. So, are you still having those? Is it like weekly, monthly, or is that kind of...?

Participant: We did it – it was – we had Policy – we called them the HIV Policy Meetings – but they were having them daily, obviously, and then they went to three times a week, and then they went to weekly, then they went to every other week, and then I

think we were doing them monthly for a while. And now, we haven't had one in a while and we were actually – we had one scheduled in February and I think we got snowed out or something, something happened and so we haven't got it rescheduled yet. But we are – that is on our plan, to have one every once in a while just to kind of keep everybody updated.

Interviewer: Okay. So, who's a part of that? The Health Department? Is it both Mayors or?

Participant: The Health Department, both Mayors are invited.

Interviewer: Their representative...

Participant: Right. LifeSpring comes...

Interviewer: And is the Sheriff?

Participant: The Sheriff always comes, yeah. He's really good about coming to those. Dr. Cook's office comes, the doctor's office up there, they come, Foundations Family Medicine, they come.

Interviewer: Do the pharmacies come? Anyone from that?

Participant: I don't think anybody from the pharmacies come.

Interviewer: Okay.

Participant: Some of the local doctors come. Our Health Officer obviously comes, but sometimes Dr. Avery will come. He's another doctor who helped us get it – get the needle exchange going. Sometimes he comes. And he's the Medical Director of the hospital, I think now. So he comes sometimes. Oh, the Scott Memorial Hospital is always there. They always have a representative there. Who else? I'm trying to picture faces (LAUGHING).

Interviewer: Yeah, you're fine.

Participant: And then the Commissioners, of course, always come; several of them always come.

Interviewer: And the Health Board?

Participant: Yeah, people from the Health Board. And then we have a group – a coalition called the Get Healthy Scott County Group, and it was actually designed after – gosh, how long ago was it when the very first health ranking came out? And we were

ranked 92 out of 92, like we're the worst county. And so since we were the worst, they designed this Get Health Scott County Group and that coalition a lot of times will have someone come to the meetings too because they're really, really involved in the health of the community, so.

Interviewer: Okay. Very nice. So, what is something else that you think that the Health Department could do for this epidemic? Or, you, you know, think that would be helpful?

Participant: What do you think the Health Department could do? Good question. I'm so busy keeping my head above water now. You know what I mean? Like it's been a chaotic year and just – we're just treading water at this point. Things are getting better though, because like our administrative assistant quite like right in the middle of all this crap. So we were like – so like I was trying to do her job and my job, and our HIV tester quit and so we had to have an HIV tester, and so our – we got to hire another nurse, but our other nurse had to go for HIV training so she could test because we didn't have any tester. It's like we've been running around – running, chasing our tails. I mean, our number one thing, obviously, is to get the needle exchange, you know, extended for another year, because we really, really need that at this point to keep that spread of disease down. And substance abuse treatment options are like our big thing right now because I'm a big proponent of not just getting people on their HIV meds, but keeping them compliant with their meds. That's the problem we're having now, people are compliant, they're not taking their pill every day or they'll have a script up there when they run out of pills and they won't go pick it up, or they have different reasons for not being compliant. And people keep asking me, well, how can we get people compliant on medications? And I'm like, you're not going to get all these people compliant on meds until you give them substance about treatment. Because that's all they care about is their next fix. You know what I mean?

Interviewer: Yes, yes.

Participant: They're not in the right mindset to know I need to take this pill every day to save my life. So that is probably our biggest – our next biggest battle – is trying to get those substance abuse treatment options out there so that we can get more people to quit and then to get more people on HIV meds and compliant with it, so we don't have a bunch of people with AIDS in a few years, for years.

Interviewer: So, how have you spread information and educated people on this matter?

Participant: That's good. Of course, the news media was insane, and so what I learned pretty quickly is that you've got to give a little and you've got to take a little with them. And so, if you give them a little bit, then sometimes they'll help you out, and you're like – there's -- even today, there's certain – our news media is in Louisville basically. So there's certain people in Louisville we have their cellphones, and we're like, we'll call

them, we'll say, hey, this is the info I need to get out to people, and they'll come up and help – you know what I mean, they're like – so help us get that story out. And so news media was huge. Basically, everywhere I went I talked to people, so, it was like one-on-one was a big one. We had – the State Department of Health did a lot of billboards. They paid for those, had a lot of billboards put up about getting tested, about how HIV spreads, different things like that. They actually had mailers they sent out in the mail to everybody. So they sent it like to every house in our community, they sent, you know, information about testing and the one-stop shop, there was information about that. So mailers was a big thing. They had radio advertisements that would, you know, educate people. What else? Basically anytime anyone came into the one-stop shop where we saw them and where we were, you know – we were educating about HIV in the beginning and then about the needle exchange because people would get all upset about that. But then when you'd sit and explain it to them, they were like, oh okay, well I get it now, you're not just throwing needles at people. No it's not like a parade...

Interviewer: Yes.

Participant: So once you explain that program, then they would understand. So there was a lot of education that way too. And then we – I mean, we've gone to the schools even. Like we had – we had a group that came into our schools right after the HIV outbreak to do education to the kids. The smaller kids got education on needle safety; like if you see a needle, don't touch it; don't pick it up. And then the bigger kids got education on that plus the HIV and how it's spread and all that fun jazz so.

Interviewer: Okay. So, what are some other problems that the Health Department could be facing from this?

Participant: Oh, exhaustion? That is one. We're all really tired, but one of our biggest fears, obviously, is that people aren't going to get treatment. I mean, the HIV treatment options – the ARVs, antiretrovirals, are so much improved from what they used to be. It's a pill once a day; like it's so simple like to you and me.

Interviewer: Right.

Participant: But getting people to take their meds and stay on their meds to keep those viral loads down, that's a huge process.

Interviewer: Okay.

Participant: So, that's one of the things that we're really worried about that a few years from now, we're going to have a lot of people with AIDS, you know, that are – that can spread it more easily. You know what I mean? Like if they get that viral load down, they can't spread that virus to other people. And so if they actually have full-blown AIDS, they can spread it more easily. And so, of course, we're always worried about

new positives, but we're worried about the people that have HIV staying on their meds. So that's a big thing. And one of our other problems is the Hep C. So that's going to be a huge challenge to us in the next couple years, is trying to get more and more people treated for hepatitis C, because I think we're at 95 – 93 or 95 percent of our HIV positives are co-infected with Hep C.

Interviewer: Wow.

Participant: So they already have Hep C. And so if you have Hep C and then you get HIV, well the HIV attacks your immune system and your immune system craps out, and that Hep C virus just takes over. And so we're very worried we're going to have a lot of hepatitis C. We'll have a lot of really sick people here in a few years.

Interviewer: That's insane.

Participant: It is insane. And so that's one of our biggest fears, like we need to get more treatment options for Hep C so that we can get people treated, or I mean ten years down the road, I mean, we're doomed. Like, there's not enough livers in the world, you know what I mean, to do liver replacements on everybody. So we have to get more people treated on that, so.

Interviewer: Wow, okay. So, what effects have these issues had on the – like on the department here?

Participant: Some good and some bad, obviously. Like I said, we're tired, but you know, Patty and Jackie and I – we do the majority of the work on all this and so we are just kind of exhausted, which is – I mean, that's fine – if we're helping people, you know, that's what we do. There's a lot of good that came from it too. Our infrastructure is getting better. We have a part-time administrator right now who only works like ten hours a week and we're getting a full-time administrator. They're actually starting interviews this week. So we'll have a full-time administrator that can help us because we have a lot of issues. I mean, obviously, we're 92 out of 92 for six years now I think they said. So we have a lot of issues and so that I think will help. I've gotten to hire a nurse. I was the only public health nurse in our community and so we've gotten to hire another nurse, which has been a tremendous asset. We now have an HIV tester that can go out and test anybody, anytime, anywhere, and she can do more education. So we've got more staffing obviously, which has been a tremendous asset and then that allows us to do more. You know what I mean?

Interviewer: Yeah, yeah.

Participant: Like I didn't have time to do anything because I'm too busy and so having those other people have been – has been a tremendous asset. I think it has helped us, too, since we all had to work together, like we had to work with the Prosecutor, we had to

work with the Sheriff, we had to work with, you know, Get Healthy Scott County and the CEASe group and LifeSpring, and so I think that has been a tremendous asset too, that we've all learned how to work together. And now I have, you know, I can call so-and-so up and say hey, this is a problem we're having and we work through it and we figure it out. Or even the CDC, I mean. I sent an email to somebody from CDC, I'm like, hey, you know, I'm having trouble coming up with a policy for Narcan, do you have any tips? And they send me names and...

Interviewer: Oh, wow.

Participant: So it was like, bam, like that. I'm like, man, it's nice knowing somebody at CDC that can, you know, answer your questions. It sucks that they had come here, but at least now we have their, you know, personal email. So I think that's probably it.

Interviewer: Okay. So, before this epidemic occurred you were kind of talking about the Department didn't really know a lot about HIV and AIDS, in general, and even Hep C. And so, what little understanding do you think they had here?

Participant: The people in the community?

Interviewer: No, the Department here.

Participant: Us? The Health Department? Very, very little. I had educated myself quite a bit on Hep C because our numbers of Hep C were really large, but the thing about Hep C was, I'd go to different meetings with different people – different public health nurses all over the state and they were all saying the same thing. Because I'm like, is this odd? I'd talk to the surveillance coordinator at the HIV Department – HIV-HepC Department – and she was like everybody's saying the same thing. So it wasn't something abnormal just for us, but I knew the numbers were large and so we actually had some trainings where we had the State come in and do some teaching and training and such. So I had trained myself pretty – I thought I knew Hep C pretty well. But HIV, I never had to deal with it, so I had to start from scratch, which was kind of hard, you know, for me, but I'm a nurse, so I picked it up pretty quickly. But other people in the Health Department don't even have a medical background and they're having to learn about HIV and Hep, you know what I mean, Hep C and everything from scratch. It was very hard for some of them. Especially our Preparedness Coordinator, you know, she's having to run the preparedness side of it where everybody's coming in and all these people, and managing all these people and all this stuff – and she had to learn very quickly about HIV and everything. And now, like our new administrative assistant that started, the hospital has HIV core trainings and it teaches people the basics of HIV...

Interviewer: Oh, okay.

Participant: And so she went to that today and she's like "I learned so much!" And I'm like "I know, I learned from scratch!" So, I think it was like from zero to a hundred there pretty quickly. We had to teach ourselves pretty quickly and it was a little bit easier for me because I had the nursing background, but some of them basically started from scratch.

Interviewer: Wow, that's crazy. So what is something that you think that you could be doing here at the Health Department that you're not doing, that you want to do?

Participant: Good question. Actually at the Health Department?

Interviewer: Um hm.

Participant: I don't know. I mean, I think we're – we're doing almost all that we can and we – I mean, we as the Health Department can't do it all...

Interviewer: Right.

Participant: So that's why I think it's good that we have all these connections now. So like LifeSpring brought in the FQHC. Like, I would have said, we need a medical clinic to help people, but LifeSpring did that. And we need a dental clinic, and they said that they're hoping to bring a dental clinic up, too. So, I'm like, okay great, check that off my list. You know what I mean? Like, the Health Department can't do it all and to have all these other entities that are trying to help bring in services – that is tremendous – and so of course, we're going to support them any way that we can. What am I doing – what would I love to do? I don't know. Really, just to get back to my regular job. I have like so much work to do in my office and I'm never in there. So, I think really that's it. You know, the medication assisted therapy like the MAT? We can't give that, but we can help support LifeSpring or whoever's going to bring that in. We definitely need a detox center because there's no place for people to detox. And LifeSpring has said their Turning Point – their inpatient – that they only have so many detox beds. So, that's the hold up. That's why it takes so long, because there's a hold up for the detox bed before they can move into the actual center. So, if we had a detox center, we could detox them and then they could go directly in. And so the hospital is actually working on that, they're trying to get that. Our community needs homeless shelters. People are living on the streets and in their cars, it's ridiculous. So we need a homeless shelter. So that's something that we don't have. There's a group that's actually coming in and – you know Englishton Park in Lexington?

Interviewer: Um hm.

Participant: They are actually going to try to turn that into a women's and children shelter.

Interviewer: Oh, wow.

Participant: So it'll be like a transitional shelter for women and children. So, you know, I mean there's all these needs, but there's all these different entities that are coming together to try to do it. So I think that's fabulous. We're all kind of helping each other and figuring out what we need.

Interviewer: Yeah, that's awesome. So is there anything else that you can think of that you want to add that you think might be helpful to understanding all this?

Participant: No, nothing that I can think of.

Interviewer: Alright. Well, thank you for your time. I really appreciate it.

(END INTERVIEW)

Interview 7

Interviewer: Can you talk more about the Scott County Health Department's involvement with the AHF?

Participant: The Scott County health department felt that they could begin and sustain their own needle exchange without the assistance of the AHF. We felt that doing it on our own would be a better approach. When the county health nurse, (name deleted), spoke with the AHF about running the needle exchange program and they said, "Well I know you've probably seen the lawsuits but don't worry about that." I'm not sure if you've seen in the news but there was an article recently put out about Clark County and working with the AHF to start a needle exchange program. They've been working with them for almost a year now to be authorized for this program and they still aren't approved. Some counties that are doing the needle exchange program have obtained approval in 48 hours. So this was just another confirmation of why we shouldn't work with the AHF.

Interviewer: How did Austin get involved with the AHF?

Participant: There isn't a lot of conversation with Austin and they seem to do their own thing. For example, I just found out today that Dr. Cooke is speaking at this thing in Louisville on a panel for HIV/AIDS and drug use, and the health department isn't even a part of it. We just got an email and here's the journal. In dealing with the needle exchange, we just worked with the state department of health and the CDC and felt it was the best to run our own needle exchange instead of involving the AHF. They had a

meeting that they weren't asking the AHF to come in and everyone was in agreement – Literally the next week the AHF was in Dr. Cooke's office.

Interviewer: Who had the meeting?

Participant: Dr. Cooke, the Scott County health department, commissioners, Austin and Scottsburg Mayors, and some others. The real issue is that each of these people in these meetings think that their ways are correct and do not communicate. I've never spoken to Dr. Cooke within the one month I've been working here. I have also been speaking with (name removed) and she runs the LLC- Local something coalition but every county has one. I'm not sure how she became the head of many of the HIV and Drug activities or if she made herself the HIV/Opioid communicator- but she is always sending me emails about Dr. Cooke and other activities that are going on in the community.

Interviewer: What is (name removed) title?

Participant: (name removed) title says Coordinator and I know she's over CEASE.

Interviewer: Anything else you would like to add?

Participant: Basically our opinion is that we felt that we could operate the needle exchange with our own resources. Also, there's no dialogue between Austin and the Scott County Health Department about what each are doing for the drug problem or HIV problem.

Curriculum Vitae

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Education

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Scholarship

Conference Papers/Presentations/Posters

Goodin, Lisann (2015, May). *The relationship of organizational climate and job satisfaction within five hierarchical classifications* Paper presented at the International Communication Conference, Wroclaw, PL

Manuscripts/Projects in Progress

Goodin, Lisann. (in progress). A case study of community response to a health crisis from a communication perspective.

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Indiana University Purdue University of Indianapolis, August 2015 – Present
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Fellowships, Awards, & Recognition

Graduate Travel Award, April 2015
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Professional & Service Organizations

National Communication Association, Member: 2014 – Present

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